

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
04400

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04396

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>10 wks</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				30-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Church Home, Inc</u>				d. STREET ADDRESS <u>2128 W. Lexington</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>William</u> Last <u>Asendorf</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>21</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 1, 1880</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>21</u> Hours <u>10</u> Min.		IF UNDER 24 HRS. Hours <u>10</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Albert Asendorf, sr.</u>				14. MOTHER'S MAIDEN NAME <u>Emma Ghienmeyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-09-1264</u>		17. INFORMANT <u>Charles Wagner, Lt.</u> Address <u>2750 Va Ave Williamsport, Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gen. Arteriosclerosis</u> <u>4500</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15</u> 19 <u>66</u> to <u>Mar 21</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Mar 17</u> 19 <u>66</u> , and that death occurred <u>5:15 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert P. Conrad</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>3-21-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>				22d. ADDRESS <u>137 W. Washington Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/23/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town, or county) <u>Baltimore Maryland</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> Address <u>Funeral Home Inc</u>				25a. REC'D BY REGISTRAR <u>MAR 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

BP

CERTIFICATE OF DEATH

1930

1930

W. H. HARRIS & SONS, LTD.
10, Abchurch Lane, London, E.C. 4
Incorporated in England
No. 10427 of 1929
The above-named company is a limited liability company
and is registered in the Companies Register of England
under No. 10427 of 1929.
The above-named company is a limited liability company
and is registered in the Companies Register of England
under No. 10427 of 1929.
The above-named company is a limited liability company
and is registered in the Companies Register of England
under No. 10427 of 1929.
The above-named company is a limited liability company
and is registered in the Companies Register of England
under No. 10427 of 1929.

THE GENERAL REGISTRY
LONDON

1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in subsequent, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04401

CERTIFICATE OF DEATH

04397

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 17 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2103 Virginia Ave.				d. STREET ADDRESS 2103 Virginia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JAMES Middle KELLER Last BENEDICT				4. DATE OF DEATH Month March Day 21 Year 1966				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 31, 1895		
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) actlyne burner			10b. KIND OF BUSINESS OR INDUSTRY navy yard		11. BIRTHPLACE (County & State, or foreign country) Waynesboro, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ohlick Benedict				14. MOTHER'S MAIDEN NAME Virginia Thackey				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W W I 705-10-6176		17. INFORMANT Margaret Benedict Hag., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Atherosclerosis DUE TO (c) Malignancy Of Bladder							INTERVAL BETWEEN ONSET AND DEATH Instant 8 years 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1965 , to Mar. 21, 1966 , that (I) (we) last saw the deceased alive on Mar. 2, 1966 , and that death occurred at 9:10 M. from causes and on the date stated above.								
22a. SIGNATURE <i>[Signature]</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-21-66		
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.				22d. ADDRESS 215 W. Washington St., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3/24/66		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Md.		
24. FUNERAL DIRECTOR Minich Funeral Home Hagerstown, Md.				25a. REC'D BY REGISTRAR MAR 24 1966		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

5420

0040

MAR 2 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04402					04398				
1. PLACE OF DEATH a. COUNTY Washington					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland			c. LENGTH OF STAY IN 1b 1 yr. 3½ mos.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville, Maryland.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital					d. STREET ADDRESS 616 Douglas Avenue				
3. NAME OF DECEASED (Type or print) George Howard Black					4. DATE OF DEATH March 22 1966				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1911		9. AGE (in years last birthday) 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Unknown			12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 214-28-9820		17. INFORMANT Western Maryland State Hospital				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma of lung</i> 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>carcinoma of esophagus</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 6 weeks 21 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12/31, 1964, to 3/22, 1966, that (I) (we) last saw the deceased alive on 3/22 1966, and that death occurred at 5 PM, from the causes and on the date stated above.									
22a. SIGNATURE Victor L. Ramos, M.D.					22b. DATE SIGNED March 23, 1966		22c. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3-28-1966		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.		
24. FUNERAL DIRECTOR John R Watson Jr Hagerstown Md.					25a. REC'D BY REGISTRAR MAR 29 1966				
25b. REGISTRAR'S SIGNATURE Charles Judge									

1939

1939

Feb 22, 1939

214-28-1220

meteoritic composition of iron
occurrence of sulphides

3/22

3/22

Victor L. Jones, Jr.
Victor L. Jones, Jr.

March 22, 1939
Victor L. Jones, Jr.
Victor L. Jones, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04403

CERTIFICATE OF DEATH

04399

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 1 yr 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Williamsport Sanitarium		d. STREET ADDRESS RFD 2	
3. NAME OF DECEASED (Type or print) First William Middle Herbert Last Bollinger		4. DATE OF DEATH Month March Day 17 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1882
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) barber		10b. KIND OF BUSINESS OR INDUSTRY barber shop	
11. BIRTHPLACE (County & State, or foreign country) Altoona, Penna.		12. CITIZEN OF WHAT COUNTRY? Altoona, Penna.	
13. FATHER'S NAME Harry Bollinger		14. MOTHER'S MAIDEN NAME Harriett Whittaker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 184-26-4460	
17. INFORMANT Mrs. B. Beard, 43 N. Pot. St.		Address Waynesboro, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH 7 days 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 66 , to March 17 , 19 66 that (II) (we) last saw the deceased alive on March 17 , 19 66 , and that death occurred at 7:30 M, from causes and on the date stated above.			
22a. SIGNATURE M.E. Byrkit			22b. DATE SIGNED 3-19-66
22c. PHYSICIAN'S NAME (Type) M.E. Byrkit			22d. ADDRESS Williamsport Md
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3-19-66	23c. NAME OF CEMETERY OR CREMATORY Leitersburg Cemetery	23d. LOCATION (City or Town) (County) (State) Leitersburg, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Smithsburg, Md.		25a. REC'D BY REGISTRAR MAR 21 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
04404									
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 12 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 629 OAK HILL AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM GETTY BOWEN, JR.			4. DATE OF DEATH MARCH 7 19 66			5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH FEB. 24, 1966 9. AGE (In years last birthday) 12 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM G. BOWEN, SR.					14. MOTHER'S MAIDEN NAME KRISTIN GRICE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT WILLIAM G. BOWEN SR. 629 OAK HILL AVE.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstital Viral Pneumonia 7630 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None (c) None								INTERVAL BETWEEN ONSET AND DEATH several hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 2/24 , 1966, to 3/7 , 1966, that (I) (we) last saw the deceased alive on 3/7 1966, and that death occurred at 4:00 PM , from the causes and on the date stated above.									
22a. SIGNATURE H. D. BOWMAN M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/8/1966		
22c. PHYSICIAN'S NAME (Type) H. D. BOWMAN M.D.					22d. ADDRESS 318 N. POTOMAC ST. HAGERSTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 3/8/1966		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION (City, town or county) (State) HAGERSTOWN, MARYLAND		
24. FUNERAL DIRECTOR Charles R. Royce					25a. REC'D BY REGISTRAR MAR 10 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		
6-162 457									

1115-1121

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04401

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN lb 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY JAIL		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE MARYLAND f. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK d. STREET ADDRESS HANCOCK a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN LEWIS BREEDEN First Middle Last		4. DATE OF DEATH Month 24 Day 23 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/1914
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WESLEY BREEDEN		14. MOTHER'S MAIDEN NAME MARY ANN FRAZIER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT WARNER BREEDEN, RFD #2 BERKELEY SPRING		Address W.VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated Duodenal Ulcer 5411 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized Peritonitis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5-7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III		22. DATE SIGNED 3-24-66	
EXAMINER'S NAME (Type) EDWARD W. DITTO III		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/26/66	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET PRESBYTERIAN	23d. LOCATION (City, town or county) (State) WASHINGTON CO. MD.
24. FUNERAL DIRECTOR Richard J. Lorne		25a. REC'D BY REGISTRAR MAR 28 1966	
ADDRESS HANCOCK, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04406											
04402											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 Days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>21-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Md. State Hospital</u>						d. STREET ADDRESS <u>1572 Broadfording Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RENNER</u>			First <u>RENNER</u> Middle <u>(NMN)</u> Last <u>Brewer</u>			4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 20, 1883</u> <u>83</u> yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Clear Spring Wash Co Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Otis Brewer</u>						14. MOTHER'S MAIDEN NAME <u>Matilda Renner</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Helen Durbin</u> Address <u>Rd</u>				1572 Broadfording	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary</u> <u>Hagerstown Md.</u> INTERVAL BETWEEN ONSET AND DEATH <u>4201</u> DUE TO <u>Generalized arteriosclerosis</u> <u>Hours</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>years</u> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 15</u> , 19 <u>66</u> , to <u>Mar. 17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Mar. 17, 1966</u> , and that death occurred at <u>2pm</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Efren A. Ramirez</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Mar. 17, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Efren A. Ramirez, MD</u>						22d. ADDRESS <u>1500 Penn. Ave., Hagerstown Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3/21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Pauls Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>near Clear Spring Wash Co Md</u>			
24. FUNERAL DIRECTOR <u>Hagerstown</u> <u>Andrew K. Coffman</u>						ADDRESS <u>Md</u> <u>Funeral Home Inc</u>		25a. REC'D BY REGISTRAR <u>MAR 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

100-100

100-100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04407 CERTIFICATE OF DEATH 04403

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 52 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 817 DEWEY AVE.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 817 DEWEY AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RANDALL TIRNEY BURNETT		4. DATE OF DEATH Month Day Year MARCH 6 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 27, 1887
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED JEWELER	
10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS		11. BIRTHPLACE (County & State, or foreign country) ROANOKE, CO., VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES BURNETT	
14. MOTHER'S MAIDEN NAME LILY RANDALL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 220-18-1975		17. INFORMANT EDWARD OSWALD, JR.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH minutes 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar-3 , 19 66 , to Mar-6 , 19 66 , that (I) (we) last saw the deceased alive on Mar-6 , 19 66 , and that death occurred at 8 A M, from the causes and on the date stated above.			
22a. SIGNATURE Lloyd A. Hoffman		22b. DATE SIGNED 3/7/1966	
22c. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN M.D.		22d. ADDRESS 214 N. POTOMAC ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MARCH 8, 1966	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City, town or county) (State) HAGERSTOWN MARYLAND
24. FUNERAL DIRECTOR Charles S. Rouse		25a. REC'D BY REGISTRAR MAR 10 1966	
ADDRESS HAGERSTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

1000

10

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04404

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland c. LENGTH OF STAY IN 1b 50yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 309 1/2 N. Jonathan Street		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland d. STREET ADDRESS 309 1/2 N. Jonathan Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GODFREY N.M.N.		4. DATE OF DEATH Mar. 10 1966	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Charles Town, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Carter		14. MOTHER'S MAIDEN NAME Carrie Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Coretta Carter		Address 309 1/2 N. Jonathan St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic alcoholism			INTERVAL BETWEEN ONSET AND DEATH Sudden Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Howard N. Weeks, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Howard N. Weeks, M. D.		Address (Street, city, town, or county) 580 Northern Ave., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-14-1966	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR John R Watson Jr. Hagerstown Md.		25a. REC'D BY REGISTRAR MAR 14 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 3/11/66	

01100

01100

... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..

... ..
... ..
... ..

... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 6 Mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garlock Memorial Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 900 Concord St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MARIA ANGELA CIMEPELLA			First Middle Last		4. DATE OF DEATH March 3 1966		Month Day Year		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20, 1886		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) San Lorenzo, Rome			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Colonnelli					14. MOTHER'S MAIDEN NAME No Record				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-44-6506		17. INFORMANT Mrs. Rose Cordelli, 900 Concord St Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 months Several years								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov. 1965 , to March 3, 1966 , that (I) (we) last saw the deceased alive on March 2, 1966 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Dr. E. W. Ditto, Jr.			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-4-66				
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.			22d. ADDRESS 215 W. Washington St., Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/5/66		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.		
24. FUNERAL DIRECTOR A. K. Coffman Funeral Home, Inc.			ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR MAR 9 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04410

04406

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 2Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		d. STREET ADDRESS 8 West Water St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary		First Middle Last Elgie Colliflower		4. DATE OF DEATH Mar. 19 1966			
5. SEX Female	6. COLOR OR RACE Wite	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13 1881		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lavern Operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Smithsburg md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Luther Spielman				14. MOTHER'S MAIDEN NAME Zilpha Pugh			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-30-9531		17. INFORMANT Harry G Koontz		Address Smithsburg Md. R.F.D. #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Left</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Thrombosis</i> (c) <i>Anterior - S clonus & Antitroch anterior fracture left</i>						INTERVAL BETWEEN ONSET AND DEATH 3/12/66 3/12/66	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Antitroch anterior fracture</i>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 3/12/66 8:00 p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Residence</i>		20f. (City or town) (County) (State) <i>Smithsburg md</i>	
21. I certify that (I) (this hospital) attended the deceased from 3/12/66 to 3/19/66 that (I) (we) last saw the deceased alive on 3/19/66 and that death occurred at 7:45 PM from the causes and on the date stated above.							
22a. SIGNATURE <i>Geo G Kohler</i>				22b. DATE SIGNED 3/20/66		22c. PHYSICIAN'S NAME (Type) G A Kohler	
22d. ADDRESS Smithsburg							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 21, 1966		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City, town or county) (State) Smithsburg Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home				ADDRESS Smithsburg Md		25a. REC'D BY REGISTRAR MAR 23 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1910



00000

Form with multiple sections for recording death information, including fields for name, date, and cause of death. The form is mostly blank with some faint markings.



1
M
79
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
04411
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 12, 14 Film G573 4/4/66 mn
CERTIFICATE OF DEATH
04407

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 15 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		21	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 126 E. Franklin St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle CHARLES Last COLLINS		4. DATE OF DEATH Month March Day 26 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1884
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sheet metal worker		10b. KIND OF BUSINESS OR INDUSTRY metal mfg.	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 094-16-6589	
17. INFORMANT Rachel Kochenour, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emphysema 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sev. years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Past several years , 19____, that (I) (we) last saw the deceased alive on 3/26/66 19____, and that death occurred at A M, from causes and on the date stated above.			
22a. SIGNATURE Howard N. Weeks		22b. DATE SIGNED 3/28/66	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 580 Northern Avenue Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-29-66	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAR 30 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

04405

GEORGETOWN OF DEATH

04412

in London

in London

in London

Washington County, Maryland

in London

in London

in London

in London

00-1-10-100

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

in London

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04412 CERTIFICATE OF DEATH 04408									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 45 Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital					d. STREET ADDRESS 310 E. Franklin St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Edward CUSHWA			First Middle Last		4. DATE OF DEATH March 31, 1966		Month Day Year		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1920		9. AGE (In years last birthday) 45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, M^d.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Walter B. Cushwa					14. MOTHER'S MAIDEN NAME Mary Baker				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 214-09-8814		17. INFORMANT Anita Cushwa Hagerstown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cirrhosis of liver 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Nephrosclerosis								INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 24, 1966 to March 31, 1966 , that (I) we last saw the deceased alive on March 31, 1966 , and that death occurred at 3:30 PM , from the causes and on the date stated above.									
22a. SIGNATURE Victor L. Ramos, M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 1, 1966		
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.					22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 4/1/66		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.					25a. REC'D BY REGISTRAR APR 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

Western Maryland State Normal
Hagerstown, Md.
April 1930

William Edward Connor
April 1930 42
March 31 60

Students of Liver
Aphrodisiacs

March 31, 60
Victor L. Jones, M.D.
Director of Research
Hagerstown, Maryland
April 1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04413

CERTIFICATE OF DEATH

04419

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 68 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 546 Salem Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NAOMI Middle MINNIE Last DE MOTTEIS				4. DATE OF DEATH Month March Day 25 Year 19 66			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1897	9. AGE (In years lost birthday) yrs. 68	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Taylor Shaffer				14. MOTHER'S MAIDEN NAME Sarah Pompell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Ernest DeMotteis, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 360X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH 2 hrs 5 yrs 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-2-66 , 19 66 , to 3-25-66 , 19 66 , that (I) (we) last saw the deceased alive on 3-25-66 19 66 , and that death occurred at 6:20AM , from causes and on the date stated above.							
22a. SIGNATURE John C. Morton				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-25-66	
22c. PHYSICIAN'S NAME (Type) John C. Morton, M. D.				22d. ADDRESS 580 Northern Ave., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3-28-66		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR MAR 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

00011

Washington County Hospital

Age 68 years

Married

Occupation

Washington County Hospital

Age 68 years

Married

Occupation

Localities

Age 68 years

Married

Occupation

Taylor Station

Age 68 years

Married

Occupation

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04414

04410

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 25 Yrs			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 113 No Mulberry St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KENNETH LEROY DIXON				4. DATE OF DEATH Month March Day 15 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 7 1934	
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cutter				10b. KIND OF BUSINESS OR INDUSTRY Dorbee Mfg Co		11. BIRTHPLACE (State or foreign country) Oakland Garrett Co Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Glen Dixon				14. MOTHER'S MAIDEN NAME Erna Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. Korean		17. INFORMANT Mrs Erna S. Dixon Address 113 No Mulberry St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH Sudden Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Howard N. Weeks</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Hagerstown, Md.			
EXAMINER'S NAME (Type) Howard N. Weeks, M.D.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/17/66		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Men Gardens		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Hagerstown				25a. RECORD BY REGISTRAR Andrew K. Coffman Funeral Home Inc			
ADDRESS Hagerstown				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 21 1966

11110

11110

[Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04411

FOR STATE
HEALTH DEPT.

04415

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 61 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1229 Salem Ave.		e. STREET ADDRESS 1229 Salem Ave.	
3. NAME OF DECEASED (Type or print) First HAROLD Middle JENNINGS Last DONALDSON		4. DATE OF DEATH Month March Day 21 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1904
9. AGE (In years lost birthday) yrs. 61		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) accountant		10b. KIND OF BUSINESS OR INDUSTRY furniture mfg.	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Donaldson		14. MOTHER'S MAIDEN NAME Ida Spessard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ((If yes give war or dates of service)) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mildred Donaldson, Hag., Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Alcoholism DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Several years 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE A. W. Ditto, Jr.		22. DATE SIGNED 3-21-66	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3-23-66	23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Gar.	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25. REC'D BY REGISTRAR DATE MAR 24 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

U-111

111-111

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

1200 Salem Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
20 M 1/66

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
04416					CERTIFICATE OF DEATH					04412				
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro					c. LENGTH OF STAY IN 1b 6 Years					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro Rfd. 2 21-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rfd. 2					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last George Walker Downing					4. DATE OF DEATH Month Day Year March 26, 19 66									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 8, 1888		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 7 18		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner				10b. KIND OF BUSINESS OR INDUSTRY Nursury		11. BIRTHPLACE (County & State, or foreign country) Troy, New York				12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME David Downing					14. MOTHER'S MAIDEN NAME Mary Unknown									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.				16. SOCIAL SECURITY NO. 112-26-0770		17. INFORMANT Mrs. Rose E. Downing, Boonsboro Rfd. 2, Md.				Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emphysema 5233 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary fibrosis DUE TO (c) Pneumonia										INTERVAL BETWEEN ONSET AND DEATH 7 years Years Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from March, 1964 , to March, 1966 , that (I) (we) last saw the deceased alive on 3-26-1966 , and that death occurred at 1P M, from causes and on the date stated above.														
22a. SIGNATURE JOSEPH SECONDARI M.D.										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-26-66		
22c. PHYSICIAN'S NAME (Type) J. Secondari										22d. ADDRESS BOONSBORO - MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3-29-66		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Clearspring, Md.						
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.						25a. REC'D BY REGISTRAR MAR 30 1966		25b. REGISTRAR'S SIGNATURE Charles Judge						

2114

01330

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04417

04413

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>335 No Potomac St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA HELEN DROSSNER</u>		4. DATE OF DEATH Month Day Year <u>March 31 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 14 1890</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mendel Mark</u>		14. MOTHER'S MAIDEN NAME <u>Yetta Fleisher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>14-09-1707</u>	
17. INFORMANT Address <u>Marvin M. Kline San Antonio Texas</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Atherosclerotic Cardiac Dis</u> DUE TO (c) <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatic neoplasia, rt. lobe; pneumonia, lobe</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4 Dec 1962</u> to <u>30 Mar 1966</u> , that (I) (we) last saw the deceased alive on <u>30 Mar 1966</u> , and that death occurred at <u>6A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard T. Binford</u>		22b. DATE SIGNED <u>1 Apr 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M.D.</u>		22d. ADDRESS <u>1135 POTOMAC AVENUE HAG. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/1/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>B'Nai Abraham Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md</u>	
24. FUNERAL DIRECTOR <u>Hagerstown Md. Andrew K. Coffman Funeral Home Inc</u>		25. RECEIVED BY REGISTRAR <u>APR 4 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04413

CERTIFICATE OF DEATH

FILE

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY AND COUNTY	
OCCUPATION		CAUSE OF DEATH	
AGE		SEX	
MARRIED		SINGLE	
BORN		DIED	
FATHER		MOTHER	
SPOUSE		CHILDREN	
BROTHERS		SISTERS	
GRANDFATHER		GRANDMOTHER	
UNCLE		AUNT	
Cousins		Nephews	
Nieces		Other relatives	
Funeral home		Burial place	
Physician		Coroner	
Witnesses		Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04413 CERTIFICATE OF DEATH 04414									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown 21-1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Clearview Nursing Home</u>					d. STREET ADDRESS <u>R # 3</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Genevieve</u> Middle <u>Irene</u> Last <u>Dunham</u>			4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4, 1915</u>		9. AGE (In years last birthday) <u>51</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife & Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augustus Henson Mallott</u>					14. MOTHER'S MAIDEN NAME <u>Myrtle Miller</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-16-1891</u>		17. INFORMANT <u>Mr. Geo. J. Dunham R # 3</u>			Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast with metastases spread</u> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>medicinal spread</u> (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>12-28</u> , 19 <u>58</u> , to <u>3-28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3-28</u> 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>John C. Stauffer</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>John C. Stauffer, M. D.</u>					22d. ADDRESS <u>Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3/31/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>		
24. FUNERAL DIRECTOR <u>Wm. G. Hox</u>					ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

John C. Stauffer, Jr., D. D., Secretary, American Board of Commissioners for Foreign Missions, Boston, Mass.

404.22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04413

04415

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Cearfoss) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 4, Hagerstown,				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Cearfoss) d. STREET ADDRESS Route 4 Hagerstown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) William Ernest Durboraw		4. DATE OF DEATH Month March Day 7 Year 19 66		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1885		9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) McCoys Ferry, Wash. Co. Md.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles A. Durboraw						14. MOTHER'S MAIDEN NAME Priscilla Kline							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Audrey Monninger-Cearfoss, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Immediate					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 3/7/66 19 , to 3/7/66 19 , that (I) (we) last saw the deceased alive on 3/7/66 , and that death occurred at 11 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Ralph F. Young				22b. PHYSICIAN'S NAME (Type) Ralph F. Young		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/9/66		22d. ADDRESS Williamsport, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-10-1966		23c. NAME OF CEMETERY OR CREMATORY Tuscarora Cemetery		23d. LOCATION (City, town or county) (State) Martinsburg, Rt. 1, Berkeley, W. Va.		24. FUNERAL DIRECTOR'S SIGNATURE Brown Funeral Home A. K. Brown					
25a. REC'D BY REGISTRAR MAR 14 1966				25b. REGISTRAR'S SIGNATURE Charles Judge									

00115

00115

Washington

Washington

Washington

(Enclosure)

(Enclosure)

Route 4, Washington

Route 4, Washington

Station

Station

Station

Station

30

June 8, 1955

June 8, 1955

June 8, 1955

Major General, Washington

Major General, Washington

Washington

Washington

Mr. Major General, Washington

Mr. Major General, Washington

Handwritten signature

Handwritten notes and stamps

Handwritten signature

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
04420					04416					
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN c. LENGTH OF STAY IN ID MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CLEARVIEW NURSING HOME					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY FRANKLIN c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHAMBERSBURG d. STREET ADDRESS 55 5th. AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EMMA		First E.		Middle E.		Last ETTER		4. DATE OF DEATH Month MARCH Day 7 Year 19 66		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 25, 1869		9. AGE (In years last birthday) 96 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) FRANKLIN CO., PENNA			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD G. ETTER					14. MOTHER'S MAIDEN NAME ANN SCHEIBLE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. CREE ROBERTSON		17b. ADDRESS CHAMBERSBURG, PENNA. 1768 LINCOLN WAY E.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hailor pneumonia 490X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 3 days		
								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) CHAMBERSBURG		20g. (County) FRANKLIN		
21. I certify that (I) (this hospital) attended the deceased from 3/7 , 19 66 , to death , 19 66 , that (I) (we) last saw the deceased alive on 3/7 , 19 66 , and that death occurred at 3/9 M, from the causes and on the date stated above.										
22a. SIGNATURE John C. Stauffer					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/9/1966			
22c. PHYSICIAN'S NAME (Type) JOHN C. STAUFFER M.D.					22d. ADDRESS 145 S. PROSPECT ST. HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 11, 1966		23c. NAME OF CEMETERY OR CREMATORY CEDAR GROVE CEM.		23d. LOCATION (City, town or county) (State) CHAMBERSBURG, PENNA.				
24. FUNERAL DIRECTOR Charles M. Pancer					ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR MAR 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

10/10

RECEIVED

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

1
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Boonsboro</u> c. LENGTH OF STAY IN lb <u>3 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fahney Keedy Memorial Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>New Windsor</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MINNIE DICKENSHEETS EYLER</u> First Middle Last						4. DATE OF DEATH <u>March 7 1966</u> Month Day Year					
5. SEX <u>7</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 7, 1882</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAY LABORER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE - HOME</u>				11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL - MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Daniel C. Dickensheets</u>						14. MOTHER'S MAIDEN NAME <u>SARAH ELIZABETH BARNES</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>NONE</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>				17. INFORMANT <u>MRS. DAISY BLACKSTEN</u> Address <u>NEW WINDSOR, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fractured Hip</u> DUE TO (c) <u>Acute pneumonitis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>5 month</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-24</u> 19 <u>66</u> to <u>March 7</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>March 4</u> 19 <u>66</u> and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>G. W. LeVan</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>3/7/66</u>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>	
22d. ADDRESS <u>Boonsboro, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>3/10/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WINTERS CEMETERY</u>				23d. LOCATION (City, town or county) (State) <u>NEW WINDSOR RURAL MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>						ADDRESS <u>NEW WINDSOR</u>		25. REC'D BY REGISTRAR <u>DATE</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1535

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04422

04418

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>8 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1852 penna Ave</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1852 Penna Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN ROBERT FISHER</u>			4. DATE OF DEATH Month Day Year <u>March 30 1966</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 30 1888</u>		9. AGE (In years last birthday) <u>77</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cavetown Wash Co Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Sanford Fisher</u>				
14. MOTHER'S MAIDEN NAME <u>Mary Jane Pryor</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>317-33-5460</u>		17. INFORMANT Address <u>Mrs Dora Fisher 1852 Penna Ave</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>1533</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of sigmoid</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr. 3 mo.</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Dec 30</u> , 19 <u>64</u> , to <u>Mar 30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Mar 30</u> , 19 <u>66</u> , and that death occurred at <u>6:54</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Lloyd A. Hoffman</u>				22b. DATE SIGNED <u>4/1/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>				22d. ADDRESS <u>214 N. Potomac St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>			
23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md.</u>		24. FUNERAL DIRECTOR <u>Andrew K. Coffman Hagerstown Md.</u>					
25a. REC'D BY REGISTRAR <u>APR 4 1966</u>				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1913

CERTIFICATE OF DEATH

1913

RECEIVED
DEPT. OF HEALTH
ALBANY, N. Y.
JAN 10 1914

1
M
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04423
04419
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN ID <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>405 Ridge Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>405 Ridge Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Viola</u> Last <u>Fisher</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 22, 1880</u>
9. AGE (in years last birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Examiner</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Janarius Miller</u>		14. MOTHER'S MAIDEN NAME <u>Laura Crilley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-3026</u>	
17. INFORMANT <u>Mrs. Ethel Lorschbaugh</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4200 DUE TO (b) <u>Secondary Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>osteoporosis</u> <u>Terminal Pneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>3 yrs.</u> <u>3-4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 25</u> , 19 <u>66</u> , to <u>March 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>March 24</u> , 19 <u>66</u> , and that death occurred at <u>10:30 P.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Philip J. Hirshman</u>		22b. DATE SIGNED <u>3/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>		22d. ADDRESS <u>159 W. Washington St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/28/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Hook</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>MAR 29 1966</u>	

11-2-50

58

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

76

11-2-50

11-2-50

11-2-50

76

11-2-50

76

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

11-2-50

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04424

CERTIFICATE OF DEATH

04420

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 45 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle CHRISTIANNE Last FOWLER		4. DATE OF DEATH Month March Day 26 Year 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1893
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 7 Days 26 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machine operator		10b. KIND OF BUSINESS OR INDUSTRY dress mfg.	
11. BIRTHPLACE (County & State, or foreign country) Mt. Alto., Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard W. Heefner		14. MOTHER'S MAIDEN NAME Agnes Monn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-09-9218	
17. INFORMANT Cletus Fowler, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crownary Occlusion 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of DUE TO (c) Carcinoma of sigmoid		INTERVAL BETWEEN ONSET AND DEATH 7 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrocephalus Bilateral Multiple Cerebral Abscess		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/22 , 19 65 to 3/26 , 19 66 , that (I) (we) last saw the deceased alive on 3/26 , 19 66 , and that death occurred 3:20 P M, from causes and on the date stated above.			
22a. SIGNATURE Donald E. Martin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Donald E. Martin M.D.		22d. ADDRESS 418 N. Potomac St. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-29-66	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR MAR 30 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04150

4252

7/12

Corvus corax

Corvus corax

Corvus corax

Hydrophorus (Hydrophorus) ...

4/25 62 3/5 62

4

3/5

James E. ...

MAR 2 1962

...

...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04425

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 21-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>140 1/2 W. Bethel St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Goeins</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1966</u>
9. AGE (In years last birthday) <u>—</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>34</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Emmett Clyde Holman</u>		14. MOTHER'S MAIDEN NAME <u>Christine Elizabeth Goeins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7625</u> <u>Atelectasis, bilateral</u> DUE TO <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>19 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/12/66</u> , 19 <u>66</u> , to <u>3/12/66</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>3/12/66</u> , 19 <u>66</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>214 N. Potomac, St., Hagerstown, Maryland</u> DATE SIGNED <u>3/18/66</u>			
ACTUAL SIGNATURE <u>Harold H. Gist</u>		M.D. <u>3/18/66</u>	
PHYSICIAN'S NAME (Type) <u>Harold H. Gist, M. D.</u>		<u>214 N. Potomac, St., Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/18/66</u>		22b. DATE THEREOF <u>3/18/66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WASH. CO. HOSP.</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Colin Schaffler, adm. Wash. Co. Hosp.</u>		24a. REC'D BY REGISTRAR <u>MAR 21 1966</u>	
ADDRESS <u>WASH. CO. HOSP.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

04151

<p>1. NAME OF DECEASED <i>John H. Smith</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15, 1880</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>Dec 10, 1905</i></p>	
<p>9. NAME OF SPOUSE <i>Mary E. Smith</i></p>		<p>10. DATE OF DEATH <i>Jan 10, 1925</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>John H. Smith</i></p>	
<p>15. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>16. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>17. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>18. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>19. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>20. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>21. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>22. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>23. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>24. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>25. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>26. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>27. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>28. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>29. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>30. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>31. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>32. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>33. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>34. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>35. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>36. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>37. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>38. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>39. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>40. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>41. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>42. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>43. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>44. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>45. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>46. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>47. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>48. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>49. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>50. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>51. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>52. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>53. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>54. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>55. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>56. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>57. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>58. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>59. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>60. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>61. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>62. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>63. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>64. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>65. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>66. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>67. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>68. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>69. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>70. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>71. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>72. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>73. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>74. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>75. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>76. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>77. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>78. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>79. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>80. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>81. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>82. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>83. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>84. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>85. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>86. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>87. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>88. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>89. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>90. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>91. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>92. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>93. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>94. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>95. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>96. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>97. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>98. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	
<p>99. SIGNATURE OF DECEASED <i>John H. Smith</i></p>		<p>100. SIGNATURE OF WITNESSES <i>John H. Smith</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04426					04422				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Washington					a. STATE Pa. b. COUNTY Franklin				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural--Mercersburg, Pa. 75-3				
c. LENGTH OF STAY IN 1b 2 weeks					d. STREET ADDRESS R.D.3				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co., Hosp.					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First HARRY Middle A. Last GORDON					4. DATE OF DEATH Month Mar. 5, 1966 Day 19 Year 19				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/8/1889		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. farming		11. BIRTHPLACE (County & State, or foreign country) Big Cove Tannery, Pa.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John J. Gordon					14. MOTHER'S MAIDEN NAME Belle Bergstresser				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 179-30-3997		17. INFORMANT Melvin S. Gordon Mercersburg, Pa., R.#3				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) chronic cordiac failure 4200 DUE TO (b) with rapid anhytemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus; pneumonia								INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Peter 16, 1966, to March 5, 1966, that (I) (we) last saw the deceased alive on March 4, 1966, and that death occurred at 9:30 A.M. from the causes and on the date stated above.									
22a. SIGNATURE John C. Stauff					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		
22d. ADDRESS					22e. MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/66		23c. NAME OF CEMETERY OR CREMATORY Fairview Cem.		23d. LOCATION (City, town or county) (State) Mercersburg, Pa.			
24. FUNERAL DIRECTOR J. M. Livingston				24b. ADDRESS Mercersburg, Pa.		25a. REC'D BY REGISTRAR MAR 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

03140

UNITED STATES OF AMERICA

5

1962-13

1962-13

1962-13

1962-13

1962-13

1962-13

1962-13

1962-13

1962-13

1962-13

1962-13

1962-13

1962-13

1962-13

1962-13

1962-13

1962-13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04427 CERTIFICATE OF DEATH 04423									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>4 Days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 21-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS <u>1709 Woodlawn Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY CLIFTON GROVE</u>					4. DATE OF DEATH Month Day Year <u>March 15 1966 19</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 16 1900</u> 66 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Works</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Indian Springs Wash Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John D. Grove</u>					14. MOTHER'S MAIDEN NAME <u>Anna E. Penner</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>214-09-8827A</u>		17. INFORMANT Address <u>Mrs Ada I Grove 1709 Woodlawn Dr</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Hemiplegia</u> DUE TO (b) <u>Right Frontal Lobe Metastasis</u> DUE TO (c) <u>Brachyogenic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rheumatic Heart Disease II B; Gastro-jejunal Ulcer</u>								INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
								<u>6 weeks</u>	
								<u>3 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2-12</u> , 19 <u>65</u> , to <u>3-15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3-15</u> , 19 <u>66</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Dalton M. Welty</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-16-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dalton M. Welty, M.D.</u>					22d. ADDRESS <u>998 Potomac Ave., Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Mem. Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>			
24. FUNERAL DIRECTOR <u>Hagerstown</u> <u>Andrew K. Coffman Funeral Home Inc</u>					ADDRESS <u>Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 21 1966</u>		
					25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>				

65454

RECEIVED

TS

Mar 1 1965
Bureau of
Agriculture

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04428

04424

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>1 Week</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>21-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>428 West Franklin St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ALICE LYDIA HANNAS</u> First Middle Last				4. DATE OF DEATH <u>Mar 31 1966</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 15 1896</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County, State, or foreign country) <u>Penna Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles Hook</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Gettle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Max M. Hannas 428 West Franklin St</u> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic-Hypertensive C-V Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>20 Jan.</u> , 19 <u>66</u> , to <u>31 March</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>31 March</u> 19 <u>66</u> , and that death occurred at <u>4:00 P.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED <u>1 April 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. N. FENDER</u>				22d. ADDRESS <u>218 N. Potomac St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Mem Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md</u>	
24. FUNERAL DIRECTOR <u>Hagerstown Md.</u> <u>Andrew K. Coffman Funeral Home Inc</u>				25a. REC'D BY REGISTRAR <u>APR 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ESPEN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04425											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					c. LENGTH OF STAY IN 1b <u>Life</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS <u>Walnut St</u> <u>Woburn Manor Nursing Home</u>						
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Leslie</u> Last <u>Harbaugh</u>					4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 19, 1886</u>		9. AGE (In years last birthday) <u>79</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Locomotive Fireman</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Adams County, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Yost Calvin Harbaugh</u>					14. MOTHER'S MAIDEN NAME <u>Rachel Witzel</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>214-09-3206</u>		17. INFORMANT <u>Mrs. Ethel Hurd</u>			Address <u>Hagerstown, Md.</u> <u>332 S. Cleveland Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Encephalopathy</u> <u>4200</u> DUE TO <u>Gonorrheal Genital</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Embolism & thrombosis</u> DUE TO <u>Arteriosclerotic Heart Disease</u> (c)										<u>3 days</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> , 19 <u>66</u> , to <u>3/25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/25</u> , 19 <u>66</u> , and that death occurred at <u>6 A</u> .M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Philip J. Hirshman</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/26/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>					22d. ADDRESS <u>159 W. Washington St., Hagerstown, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3/29/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>			
24. FUNERAL DIRECTOR <u>W. C. Hunt</u>					ADDRESS <u>Rest Haven Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

0-1152

STATE OF TEXAS

11

County of ...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
04430					04426							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY WASHINGTON MARYLAND					a. STATE MARYLAND b. COUNTY WASHINGTON							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN							
c. LENGTH OF STAY IN 1b 3 YRS					d. STREET ADDRESS 316 BUENA VISTA AVENUE							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 316 BUENA VISTA AVENUE					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year			
LUCY ANNA McALLISTER			HARR			MARCH			9 1966			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 10, 1875		9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ANDREW J. McALLISTER					14. MOTHER'S MAIDEN NAME SUSAN TRUMPOWER					HAGERSTOWN, MD.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. NONE			17. INFORMANT MRS. ROY JACOBS					316 BUENA VISTA AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis										2 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis										3-4 wks		
(c) Arteriosclerosis 1 year prior										15 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Aug 1966 , to 3-9-1966 that (I) (we) last saw the deceased alive on 3-8-1966 , and that death occurred at 3:30 AM , from the causes and on the date stated above.												
22a. SIGNATURE John C. Morton						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/9/1966				
22c. PHYSICIAN'S NAME (Type) JOHN C. MORTON M.D.						22d. ADDRESS 580 NORTHERN AVE. HAGERSTOWN, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF MARCH 12, 1966		23c. NAME OF CEMETERY OR CREMATORY LITTLE ROSE HILL CEM.			23d. LOCATION (City, town or county) (State) WASHINGTON CO., MARYLAND				
24. FUNERAL DIRECTOR Charles M. Reager						HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE MAR 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

08140

08140

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

0013-1000

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G375 4/7/66 mh

CERTIFICATE OF DEATH

04431

04427

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>4 Hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>2002 Pineknoll Lane</u> <u>Hagerstown Church Home</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY AMELIA HARTER</u>		4. DATE OF DEATH Month Day Year <u>March 30 1966</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11 1889</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst Curator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Museum</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James P. Harter Sr</u>		14. MOTHER'S MAIDEN NAME <u>Alice Heyser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-30-7539</u>	
17. INFORMANT <u>James P. Harter 111</u>		Address <u>Hagerstown Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive CV Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diverterculosis of Colon</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 15, 1965</u> to <u>3-30</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>3-30</u> 19 <u>66</u> , and that death occurred at <u>6:45</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Robert P. Conrad</u>		22b. DATE SIGNED <u>4-1-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>		22d. ADDRESS <u>137 W. Washington Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/2/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagersburg Wash Co Md</u>	
24. FUNERAL DIRECTOR <u>Hagerstown</u>		25a. REC'D BY REGISTRAR <u>APR 4 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

78140

RECEIVED

78140

78140 1000

RECEIVED
78140
1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(Rural) Fairplay RFD 1</u> c. LENGTH OF STAY IN 1b <u>5 month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairplay RFD 1</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(Rural) Fairplay RFD #1 21-1</u> d. STREET ADDRESS <u>Fairplay RFD 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Harry Thurman Henson</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 24 1902</u> 9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u> IF UNDER 24 HRS. Hours <u>13</u> Min. <u>13</u>						4. DATE OF DEATH <u>March 7 1966</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farms</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Thomas Henson</u> 14. MOTHER'S MAIDEN NAME <u>Katie Shipley</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>-----</u> 16. SOCIAL SECURITY NO. <u>213 12 7276</u> 17. INFORMANT <u>Blanche L. Henson</u> Address <u>Fairplay Maryland RFD #1</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____											
21. I certify that (1) (this hospital) attended the deceased from <u>Aug 58</u>, 19<u>58</u> to <u>March 7, 1966</u> that (2) we last saw the deceased alive on <u>March 3 1966</u>, and that death occurred at <u>1 1/2</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>M. E. Byrkit</u> 22b. DATE SIGNED <u>3-7-66</u> 22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u> 22d. ADDRESS <u>Williamsport Md</u> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>March 10-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Bakersville Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Bakersville Maryland</u> 24. FUNERAL DIRECTOR <u>Albert L. Leaf</u> ADDRESS <u>Williamsport, Maryland</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>MAR 9 1966</u>											

MEDICAL CERTIFICATION

11-1-50

RECEIVED BY DEPT. OF HEALTH

TO THE DIRECTOR OF HEALTH
FROM THE
[Illegible text]

Subject: [Illegible]
Reference: [Illegible]
[Illegible text]

Very truly yours,
[Illegible signature]
[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

79

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04433

04429

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 9 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro 21-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 326 N. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Theodore Hershberger				4. DATE OF DEATH Month Day Year March 9, 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1917		9. AGE (In years last birthday) yrs. 48	IF UNDER 1 YEAR Months Days 8 17	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Prison		11. BIRTHPLACE (County & State, or foreign country) Cresaptown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James H. Hershberger				14. MOTHER'S MAIDEN NAME Betsy Robison			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W. W. Two		16. SOCIAL SECURITY NO.		17. INFORMANT 326 N. Main St. Mrs. Anna L. Hershberger Boonsboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Posterior myocardial Infarct 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ch. Cerebral. Hemorrhage DUE TO (c) 2 day						INTERVAL BETWEEN ONSET AND DEATH 2 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 7, 1966 , to March 9, 1966 , that (I) (we) last saw the deceased alive on March 9, 1966 , and that death occurred at noon M, from causes and on the date stated above.							
22a. SIGNATURE G. W. Kavan		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/11/66			
22c. PHYSICIAN'S NAME (Type) G. W. Kavan		22d. ADDRESS Boonsboro Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3- 12- 66		23c. NAME OF CEMETERY OR CREMATORY Restlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR MAR 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

08240

DEPARTMENT OF DEATH

6811

NAME: [illegible] SURNAME: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible] PLACE OF BURIAL: [illegible]

DATE OF CREMATION: [illegible] PLACE OF CREMATION: [illegible]

DATE OF INTERMENT: [illegible] PLACE OF INTERMENT: [illegible]

DATE OF EXHUMATION: [illegible] PLACE OF EXHUMATION: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

DATE OF REINTERMENT: [illegible] PLACE OF REINTERMENT: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04434

04430

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #1, HANCOCK HOME		d. STREET ADDRESS RFD #1, HANCOCK	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AENA Middle CECELIA Last HILL		4. DATE OF DEATH Month MARCH Day 22 Year 19 66	
5. SEX WHITE	6. COLOR OR RACE FEMALE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7/9/1903
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FAIRCHILD AIRCRAFT CORP.		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANNIE KEESECKER		14. MOTHER'S MAIDEN NAME WILLIAM ELKINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-24-8638	
17. INFORMANT JAMES P. HILL RFD #1 HANCOCK, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) Coronary infarct Cardio Vasc. Disease Pulm Emphysema		INTERVAL BETWEEN ONSET AND DEATH 2 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/21 , 19 66 , to 3/22 , 19 66 , that (I) (we) last saw the deceased alive on 3/21 , 19 66 , and that death occurred at 3/22 , 19 66 , from causes and on the date stated above.			
22a. SIGNATURE A. Shaffer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) HANCOCK		22d. ADDRESS HANCOCK MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/25/66	
23c. NAME OF CEMETERY OR CREMATORY ST. PETERS CEMETERY		23d. LOCATION (City or Town) (County) (State) HANCOCK, WASHINGTON MD.	
24. FUNERAL DIRECTOR Howard J. Elmer Hancock MD		25a. REC'D BY REGISTRAR MAR 28 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04435

04431

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. STREET ADDRESS HANCOCK MD	
3. NAME OF DECEASED (Type or print) First Middle Last ELMER TRUAX HIXON		4. DATE OF DEATH Month Day Year 3 16 19 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4.7.1888
9. AGE (In years lost birthday) yrs. 77		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON COUNTY MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH F HIXON		14. MOTHER'S MAIDEN NAME NANCY E BRADY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217.12.2033	
17. INFORMANT MARY R HIXON		Address RURAL 1 HANCOCK MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 day 3 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) mild diabetes, arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/12 , 19 66 to 3/16 , 19 66 , that (I) (we) last saw the deceased alive on 3/16/66 , and that death occurred at 655A M, from causes and on the date stated above.			
22a. SIGNATURE Robert V. Campbell M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 3/18/66
22c. PHYSICIAN'S NAME (Type) Robert V. Campbell		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3.20.66	23c. NAME OF CEMETERY OR CREMATORY PRESBYTERIAN	23d. LOCATION (City or Town) (County) (State) HANCOCK WASHINGTON MD.
24. FUNERAL DIRECTOR Harold J. Snow Hagerstown Md		25a. REC'D BY REGISTRAR MAR 22 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04401

CERTIFICATE OF DEATH

04401

WASHINGTON

WYOMING

WYOMING

WYOMING

WYOMING

WYOMING

WYOMING

WYOMING

WYOMING

WYOMING

WYOMING

WYOMING

WYOMING

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-11-2011 BY 60322 UCBAW/BJS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04436

CERTIFICATE OF DEATH

04432

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro c. LENGTH OF STAY IN lb 3 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reeder Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Knoxville d. STREET ADDRESS Yarrowsburg e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles W. Hoffmaster		4. DATE OF DEATH Month Day Year March 2, 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 28, 1898
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 11 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) Yarrowsburg, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Martha Hoffmaster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 219-05-2724	
17. INFORMANT Mrs. Jewyneth Holder, Knoxville, Md.		Address Box 224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Vascular disease 4501 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gangrene of both feet DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 yrs 2 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 18 , 19 66 , to March 2 , 19 66 , that (I) (we) last saw the deceased alive on March 1 , 19 66 , and that death occurred at 7 M, from causes and on the date stated above.			
22a. SIGNATURE G. W. Hedan		22b. DATE SIGNED March 3, 1966	
22c. PHYSICIAN'S NAME (Type) G. W. Hedan		22d. ADDRESS Boonsboro, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3- 4- 66	23c. NAME OF CEMETERY OR CREMATORY Church of God Cemetery	23d. LOCATION (City or Town) (County) (State) Rural Brownsville, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR MAR 7 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04437

CERTIFICATE OF DEATH

04433

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 2 Weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Keedysville		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Rfd. 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Olive Middle Elizabeth Last Hollenshead		4. DATE OF DEATH Month March Day 21 , Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1906
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 5 Days 5 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Franklin Co. Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Blair		14. MOTHER'S MAIDEN NAME Maria Sheaffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 212-38-8591	
17. INFORMANT Mr. Leroy Hollenshead, Rfd. 1 Keedysville,		Address Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage with apoplexy 4437 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiac vasculature disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 17 days 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 4 , 19 66 to March 21 , 19 66 , that (I) (we) lost the deceased olive on March 20 , 19 66 , and that death occurred at 11 M, from causes and on the date stated above.			
22a. SIGNATURE G. W. L. L. L.		22b. DATE SIGNED March 21, 1966	
22c. PHYSICIAN'S NAME (Type) G. W. L. L. L. M.D.		22d. ADDRESS Boonsboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-23-66	23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	23d. LOCATION (City or Town) (County) (State) Keedysville, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR MAR 24 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

66-20

7382

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg Rural</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>R # 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Franklin</u> Last <u>Houser</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 9, 1910</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Houser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-36-6083</u>	
17. INFORMANT <u>Mrs. R. J. Houser</u>		Address <u>R # 1 Sharpsburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. <u>3/15/66</u>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>580 Northern Ave.</u>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Hagerstown, Md.</u>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/17/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Hester</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
		DATE <u>MAR 17 1966</u>	

04434

SECTION EXAMINER'S CERTIFICATE OF DEATH

04434

FOR STATE
IDEN. NO. 0071

DEPARTMENT OF HEALTH
STATE OF NEW YORK
SECTION EXAMINER'S CERTIFICATE OF DEATH
No. 04434
Date of Death: 10/10/1910
Place of Death: [illegible]
Age: [illegible]
Sex: [illegible]
Race: [illegible]
Occupation: [illegible]
Cause of Death: [illegible]
Manner of Death: [illegible]
Signature: [illegible]
Date: [illegible]

W. C. [illegible]
MAY 1 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

(M)

04439

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04435

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 20 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 272 So Potomac St				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 272 So Potomac St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLAUDE KNODE HUMRICHOUSE				4. DATE OF DEATH Month March Day 15 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 3 1881	
9. AGE (in years last birthday) 84 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept Manager		10b. KIND OF BUSINESS OR INDUSTRY Eyerlys Inc		11. BIRTHPLACE (County & State, or foreign country) Md. Hagerstown Wash Co	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Edward P. Humrichouse			
14. MOTHER'S MAIDEN NAME Amelia M. Knode				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 214-09-7326				17. INFORMANT Mrs Beulah W. Humrichouse			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease (c) Indefinite				INTERVAL BETWEEN ONSET AND DEATH Instant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1 , 1966, to March 15 1966, that (I) (we) last saw the deceased alive on March 9 19 66 , and that death occurred at 8:10 P. M., from the causes and on the date stated above.							
22a. SIGNATURE B. B. Kneisley				22b. DATE SIGNED 3/16/66			
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.				22d. ADDRESS 148 West Washington St. Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/19/66		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR MAR 22 1966			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

04430

04430

RECEIVED - DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 233 N. CLEVELAND AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First SUSAN Middle CAROL Last ISEMINGER			4. DATE OF DEATH Month MARCH Day 3 Year 19 66			5. SEX FEMALE			6. COLOR OR RACE WHITE		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 10/30/1939			9. AGE (In years last birthday) 26 yrs.			IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY HOME			11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CARLTON E DeHART						14. MOTHER'S MAIDEN NAME JANE DOFFLEMYER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 214-36-2499			17. INFIRMANT MR. HOWARD M. ISEMINGER JR.			Address HAGERSTOWN MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute influenza									INTERVAL BETWEEN ONSET AND DEATH 48 hours		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 3, 1966 to March 3, 1966 , that (I) (we) last saw the deceased alive on March 3, 1966 , and that death occurred at 9:15 PM , from the causes and on the date stated above.											
22a. SIGNATURE Edmund B. Hardy						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED March 5, 1966		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 3/6/66			23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.			23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.		
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.						25a. REC'D BY REGISTRAR MAR 8 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		

84438

84438

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

333 S. CLEVELAND AVE.

WASHINGTON COUNTY HOSPITAL

10-30-1930

MARCH

WASHINGTON

CAROL

BUSBY

10/30/1930

WHITE

10-30-1930

WASHINGTON

BORE

WASHINGTON

STATE HOSPITAL

WASHINGTON HOSPITAL

10-30-1930 MR. HOWARD K. LINDEN JR.

U

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04441											
04437											
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 653 HAYES AVENUE						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 653 HAYES AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GRACE MAY BELLE KISER						4. DATE OF DEATH Month MARCH Day 14 Year 19 66					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 15, 1872		9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months 20 Days 00 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) YORK CO., PENNA.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME AUGUSTUS A. LITTLE						14. MOTHER'S MAIDEN NAME MATILDA C. BUTT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. HAROLD KISER 13 FAIRGROUND AVE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 4500 DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gastro Enteritis										INTERVAL BETWEEN ONSET AND DEATH 20 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1952 , 19, to 3/14 , 19 66 , that (I) (we) last saw the deceased alive on 3/14 , 19 66 , and that death occurred at 8:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE George Jennings						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 3/15/1966		
22c. PHYSICIAN'S NAME (Type) GEORGE JENNINGS M.D.						22d. ADDRESS 318 N. POTOMAC ST. HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF MARCH 16, 1966		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY			23d. LOCATION (City, town or county) (State) HAGERSTOWN, MARYLAND		
24. FUNERAL DIRECTOR Charles S. Rouse HAGERSTOWN, MARYLAND						25a. REC'D BY REGISTRAR MAR 21 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		

04437

GENERAL OF DEPT.

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>7 month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Friendship Manor Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sharpsburg RFD #2 21-1</u> d. STREET ADDRESS <u>Antietam</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Nannie</u> First <u>Lugina</u> Middle <u>Kretzer</u> Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Antietam Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			4. DATE OF DEATH <u>March</u> Month <u>2</u> Day <u>19</u> Year <u>66</u> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>1</u> Hours <u></u> Min. <u></u> 13. FATHER'S NAME <u>John Boyer</u> 14. MOTHER'S MAIDEN NAME <u>Mary Ellen Ensweller</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>-----</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Mr. Leroy Crampton</u> Address <u>Sharpsburg RFD #2 Maryland</u>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1230, 1966, Antietam, Md</u> 20f. (City or town) (County) (State) <u>Sharpsburg Maryland</u>				21. I certify that (I) (this hospital) attended the deceased from <u>Feb 20, 1966, Antietam, Md</u> , that (I) (we) last saw the deceased alive on <u>March 2, 1966</u> , and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>J. H. Beachley</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>J. H. Beachley</u> 22d. ADDRESS <u>Hagerstown Md</u> 22e. DATE SIGNED <u>3/3/66</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>March 5 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Sharpsburg Maryland</u>				24. FUNERAL DIRECTOR <u>Jennie E. Leaf Williamsport Maryland</u> ADDRESS <u></u> 25a. REC'D BY REGISTRAR <u>MAR 7 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

200-40

STATE OF TEXAS

1882

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 1/65

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
044439									
1. PLACE OF DEATH a. COUNTY <i>Washington</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Washington</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>			c. LENGTH OF STAY IN 1b <i>60 yrs.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>			d. STREET ADDRESS <i>931 A Lawale St.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>931 A Lawale St.</i>					d. STREET ADDRESS <i>931 A Lawale St.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Clara</i> Middle <i>Elizabeth</i> Last <i>Laign</i>					4. DATE OF DEATH Month <i>March</i> Day <i>4</i> Year <i>1966</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>December 2, 1896</i>		9. AGE (in years last birthday) <i>69 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Frederick, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Edward Cramer</i>					14. MOTHER'S MAIDEN NAME <i>Harriett Koogle</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>215-26-1967</i>		17. INFORMANT <i>McClure W. Laign</i> Address <i>Canton, Ohio</i> <i>1337 S. Park Drive</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i>Generalized atherosclerosis</i>								INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i> <i>yes</i> <i>yes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>osteoarthritis; peptic ulcer; previous coronary</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>August</i> , 19 <i>61</i> , to <i>Mar 4</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Mar 4</i> , 19 <i>66</i> , and that death occurred at <i>7:30</i> AM, from the causes and on the date stated above.									
22a. SIGNATURE <i>Harold R. RITCH JR</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5/5/66</i>		
22c. PHYSICIAN'S NAME (Type) <i>HAROLD R. RITCH JR</i>					22d. ADDRESS <i>302 N. Potomac St. Hagerstown Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>3/7/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Hagerstown Md.</i>		
24. FUNERAL DIRECTOR <i>Wm. G. Hoss</i>					ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR <i>MAR 8 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>

0430

0430

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]

11. Name of informant: [illegible]
12. Address of informant: [illegible]
13. Date of completion: [illegible]
14. Signature of registrar: [illegible]

15. Name of registrar: [illegible]
16. Address of registrar: [illegible]
17. Date of completion: [illegible]

W. C. Hart

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 31 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 436 W. FRANKLIN STREET		d. STREET ADDRESS 436 W. FRANKLIN STREET	
3. NAME OF DECEASED (Type or print) ELSIE MAY LAPOLE		4. DATE OF DEATH Month MARCH Day 8 Year 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 14, 1883
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) FRANKLIN CO., PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL S. KAHLER		14. MOTHER'S MAIDEN NAME EMMA C. OVERCASH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. HELEN KAHLER		436 W. FRANKLIN ST., HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 334X DUE TO (b) Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction with dysrhythmia of heart 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 6 min Unknown Unknown
20a. TIME OF INJURY Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 1956 , to March 8, 1966 , that (I) (we) last saw the deceased alive on March 8, 1966 , and that death occurred at 2:14 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Lawrence L. Packer M.D.		22b. DATE SIGNED 3/9/1966	
22c. PHYSICIAN'S NAME (Type) LAWRENCE L. PACKER M.D.		22d. ADDRESS 145 W. WASHINGTON STREET HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 11, 1966	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City, town or county) (State) GREENCASTLE, PENNSYLVANIA	
24. FUNERAL DIRECTOR Charles M. Packer		25a. REC'D BY REGISTRAR MAR 15 1966	
ADDRESS HAGERSTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

0-1-10

1-1-10

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04445

04441

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 1 WEEK		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS MYERSDALE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE BERNARD LASHLEY		4. DATE OF DEATH Month Day Year MARCH 19, 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/22/1890
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WOODSMAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES G. LASHLEY		14. MOTHER'S MAIDEN NAME REBECCA NICCUM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT GEORGE E. LASHLEY		Address HANCOCK, MD. 160 E. MAIN STREET	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstruction of R. lung & widespread metastases 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ② Carcinoma of prostate DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute bacterial endocarditis -		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-17 19 66 , to 3-19 19 66 that (I) (we) last saw the deceased alive on 3/19 19 66 , and that death occurred at 10 A-M , from causes and on the date stated above.			
22a. SIGNATURE John H. Hornbaker		22b. DATE SIGNED 3-22-66	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker		22d. ADDRESS 154 West Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/24/66	
23c. NAME OF CEMETERY OR REMOVAL REHOBETH METHODIST		23d. LOCATION (City or Town) (County) (State) FULTON COUNTY PENNA.	
24. FUNERAL DIRECTOR Howard J. Stone		25. REC'D. BY REGISTRAR Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1520

123

XCT-112A

QNA YEAR

NEGATIVE REASON

1992 7 31 25

2324

3257-7848

27 JAN 1952

QW4275A1

REFCOA MICROV

CHARLES F. ASHLEY

• 1990 •

7-1287-11-11-25-13-15-17-19-21-23-25-27-29-31-33-35-37-39-41-43-45-47-49-51-53-55-57-59-61-63-65-67-69-71-73-75-77-79-81-83-85-87-89-91-93-95-97-99-101-103-105-107-109-111-113-115-117-119-121-123-125-127-129-131-133-135-137-139-141-143-145-147-149-151-153-155-157-159-161-163-165-167-169-171-173-175-177-179-181-183-185-187-189-191-193-195-197-199-201-203-205-207-209-211-213-215-217-219-221-223-225-227-229-231-233-235-237-239-241-243-245-247-249-251-253-255-257-259-261-263-265-267-269-271-273-275-277-279-281-283-285-287-289-291-293-295-297-299-301-303-305-307-309-311-313-315-317-319-321-323-325-327-329-331-333-335-337-339-341-343-345-347-349-351-353-355-357-359-361-363-365-367-369-371-373-375-377-379-381-383-385-387-389-391-393-395-397-399-401-403-405-407-409-411-413-415-417-419-421-423-425-427-429-431-433-435-437-439-441-443-445-447-449-451-453-455-457-459-461-463-465-467-469-471-473-475-477-479-481-483-485-487-489-491-493-495-497-499-501-503-505-507-509-511-513-515-517-519-521-523-525-527-529-531-533-535-537-539-541-543-545-547-549-551-553-555-557-559-561-563-565-567-569-571-573-575-577-579-581-583-585-587-589-591-593-595-597-599-601-603-605-607-609-611-613-615-617-619-621-623-625-627-629-631-633-635-637-639-641-643-645-647-649-651-653-655-657-659-661-663-665-667-669-671-673-675-677-679-681-683-685-687-689-691-693-695-697-699-701-703-705-707-709-711-713-715-717-719-721-723-725-727-729-731-733-735-737-739-741-743-745-747-749-751-753-755-757-759-761-763-765-767-769-771-773-775-777-779-781-783-785-787-789-791-793-795-797-799-801-803-805-807-809-811-813-815-817-819-821-823-825-827-829-831-833-835-837-839-841-843-845-847-849-851-853-855-857-859-861-863-865-867-869-871-873-875-877-879-881-883-885-887-889-891-893-895-897-899-901-903-905-907-909-911-913-915-917-919-921-923-925-927-929-931-933-935-937-939-941-943-945-947-949-951-953-955-957-959-961-963-965-967-969-971-973-975-977-979-981-983-985-987-989-991-993-995-997-999-1001-1003-1005-1007-1009-1011-1013-1015-1017-1019-1021-1023-1025-1027-1029-1031-1033-1035-1037-1039-1041-1043-1045-1047-1049-1051-1053-1055-1057-1059-1061-1063-1065-1067-1069-1071-1073-1075-1077-1079-1081-1083-1085-1087-1089-1091-1093-1095-1097-1099-1101-1103-1105-1107-1109-1111-1113-1115-1117-1119-1121-1123-1125-1127-1129-1131-1133-1135-1137-1139-1141-1143-1145-1147-1149-1151-1153-1155-1157-1159-1161-1163-1165-1167-1169-1171-1173-1175-1177-1179-1181-1183-1185-1187-1189-1191-1193-1195-1197-1199-1201-1203-1205-1207-1209-1211-1213-1215-1217-1219-1221-1223-1225-1227-1229-1231-1233-1235-1237-1239-1241-1243-1245-1247-1249-1251-1253-1255-1257-1259-1261-1263-1265-1267-1269-1271-1273-1275-1277-1279-1281-1283-1285-1287-1289-1291-1293-1295-1297-1299-1301-1303-1305-1307-1309-1311-1313-1315-1317-1319-1321-1323-1325-1327-1329-1331-1333-1335-1337-1339-1341-1343-1345-1347-1349-1351-1353-1355-1357-1359-1361-1363-1365-1367-1369-1371-1373-1375-1377-1379-1381-1383-1385-1387-1389-1391-1393-1395-1397-1399-1401-1403-1405-1407-1409-1411-1413-1415-1417-1419-1421-1423-1425-1427-1429-1431-1433-1435-1437-1439-1441-1443-1445-1447-1449-1451-1453-1455-1457-1459-1461-1463-1465-1467-1469-1471-1473-1475-1477-1479-1481-1483-1485-1487-1489-1491-1493-1495-1497-1499-1501-1503-1505-1507-1509-1511-1513-1515-1517-1519-1521-1523-1525-1527-1529-1531-1533-1535-1537-1539-1541-1543-1545-1547-1549-1551-1553-1555-1557-1559-1561-1563-1565-1567-1569-1571-1573-1575-1577-1579-1581-1583-1585-1587-1589-1591-1593-1595-1597-1599-1601-1603-1605-1607-1609-1611-1613-1615-1617-1619-1621-1623-1625-1627-1629-1631-1633-1635-1637-1639-1641-1643-1645-1647-1649-1651-1653-1655-1657-1659-1661-1663-1665-1667-1669-1671-1673-1675-1677-1679-1681-1683-1685-1687-1689-1691-1693-1695-1697-1699-1701-1703-1705-1707-1709-1711-1713-1715-1717-1719-1721-1723-1725-1727-1729-1731-1733-1735-1737-1739-1741-1743-1745-1747-1749-1751-1753-1755-1757-1759-1761-1763-1765-1767-1769-1771-1773-1775-1777-1779-1781-1783-1785-1787-1789-1791-1793-1795-1797-1799-1801-1803-1805-1807-1809-1811-1813-1815-1817-1819-1821-1823-1825-1827-1829-1831-1833-1835-1837-1839-1841-1843-1845-1847-1849-1851-1853-1855-1857-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			c. LENGTH OF STAY in 1b <u>30 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural #1 Smithsburg</u>			d. STREET ADDRESS <u>RFD #1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RFD #1</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Pauline</u> Last <u>Law</u>					4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>19 66</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1899</u>		9. AGE (In years last birthday) <u>66</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Smithsburg, Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Mayberry Law</u>					14. MOTHER'S MAIDEN NAME <u>Carrie Slick</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>					16. SOCIAL SECURITY NO. <u>215-07-9079</u>		17. INFORMANT <u>Charles E. Law Sr.</u> Address <u>RD#1 Smithsburg, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u>10 years</u> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 years</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8-27</u> , 19 <u>55</u> , to <u>3-9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3-4</u> , 19 <u>66</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Charles F. Hess</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-10-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>					22d. ADDRESS <u>Smithsburg, Maryland 21783</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>Mar. 12, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Smithsburg Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u>					ADDRESS <u>Smithsburg, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 14 1966</u>		
							25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

00000

00000

00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS <u>141 W. Franklin St.</u>				
3. NAME OF DECEASED (Type or print) First <u>Irvin</u> Middle <u>Daniel</u> Last <u>Lindsay</u>					4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 26, 1904</u>		9. AGE (In years last birthday) <u>61</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Royd Lindsay</u>					14. MOTHER'S MAIDEN NAME <u>Maude Lowery</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>214-09-0489</u>		17. INFORMANT <u>Mrs. J. D. Lindsay</u> Address <u>141 W. Franklin St. Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gastric ulcer & perforation of</u> <u>5401</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Posterior wall - 2nd Subdiaphragmatic</u> DUE TO (c) <u>Abscess</u> INTERVAL BETWEEN ONSET AND DEATH <u>7-14 days</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Mar 23, 1966</u> , to <u>Mar 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>Mar 24, 1966</u> , and that death occurred at <u>7:02</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Edward W. Ditto III</u>					22b. DATE SIGNED <u>3-26-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u>					22d. ADDRESS <u>217 West Washington St. Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3/28/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>		
24. FUNERAL DIRECTOR <u>Wm. G. Norton</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>				
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					DATE <u>MAR 29 1966</u>				

5244

• •

.....

2000 121

• www.irs.gov

250

10

125062-2203

World: Sp. 1990

21A

4. 3. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845

Wm. C. Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|--|--|---|--|---|---|---|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN b 21-1
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASH. CO. HOSPITAL | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md.
b. COUNTY Wash.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) State Line
d. STREET ADDRESS State Line
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) AARON HORST MARTIN
First Middle Last | | | | | 4. DATE OF DEATH MARCH 31 1966
Month Day Year | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/15/1901
Month Day Year | | 9. AGE (in years last birthday) 64
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY Oil Co. | | 11. BIRTHPLACE (County & State, or foreign country) Wash. Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Amos M. Martin | | | | | 14. MOTHER'S MAIDEN NAME Amanda Horst | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 217-32-5594 | | 17. INFORMANT Mrs. Susan Martin-Wash. Co., Md. | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension
DUE TO (c) Arteriosclerosis | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1 day , 1966, to 7/2 , 1966, that (I) (we) last saw the deceased alive on 3/31 , 1966, and that death occurred at 10:49M , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Edna Horschlander | | | | | 22b. DATE SIGNED 4/1/66 | | 22c. PHYSICIAN'S NAME (Type) Edna Horschlander | | |
| 22d. ADDRESS Hagerstown Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) (State) | | | |
| BURIAL | | 4/4/66 | | Reiff Cem. | | Near Clearcreek, Md. | | | |
| 24. FUNERAL DIRECTOR A.C. Minnich - Greencastle, Penna. | | | | | 25a. REC'D BY REGISTRAR APR 4 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

1994

52

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04449

04445

| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>
c. LENGTH OF STAY IN lb <u>3 Weeks</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE <u>Penna.</u> b. COUNTY <u>Franklin Co.</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pen Mar . Penna.</u> <u>75 - 3</u>
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
|--|------|--|------|--|--|--|--|---|--|---|--|---|--|-----------------|--|------------------|--|--------|------|-------|------|
| 3. NAME OF DECEASED
(Type or print) <u>Lillian</u> <u>Afolia</u> <u>Martin</u> | | 4. DATE OF DEATH
Month <u>March</u> Day <u>5</u> Year <u>19 66</u> | | 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec. 6, 1889</u> | | 9. AGE (In years last birthday) <u>76</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Harpers Ferry W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | | | | | | | |
| 13. FATHER'S NAME <u>George Diggs</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Katie Earle</u> | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mrs Mildred M Hensghel</u> | | Address <u>800 Broad Brook Bethesda Md</u> | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>466X</u> <u>pulmonary emboli</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pelvic & femoral thrombi</u>
(c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>several days</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Surgery for intestinal obstruction</u> | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/4</u> , 19 <u>66</u> , to <u>4/4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/4</u> , 19 <u>66</u> , and that death occurred at <u>4/4</u> M, from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | 22b. DATE SIGNED | | | | 22c. PHYSICIAN'S NAME (Type) <u>H.N. WEEKS</u> | | 22d. ADDRESS <u>580 North Main Ave. Hagerstown, Md</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>3/8/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Hagerstown Md</u> | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc.</u>
<u>Hagerstown, Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14400

TABLE OF TARIFFS

Page 100

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|----------------------------------|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND | | | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN | | | | | | | | | | | | c. LENGTH OF STAY IN TB
LIFE | | | | | | | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN | | | | | | | | | | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
WASHINGTON COUNTY HOSPITAL | | | | | | | | | | | | d. STREET ADDRESS
212 SUMMIT AVE. | | | | | | | | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
DORIS JANE MASSIE | | | | | | | | | | | | 4. DATE OF DEATH
Month MARCH Day 27 Year 19 66 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. SEX
FEMALE | | | | 6. COLOR OR RACE
WHITE | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
9/19/1925 | | | | 9. AGE (In years last birthday) yrs. 40 | | | | IF UNDER 1 YEAR
Months Days | | | | IF UNDER 24 HRS.
Hours Min. | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
WAITRESS | | | | | | | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
RESTUARANT | | | | | | | | | | | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | | | | | | | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | | | |
| 13. FATHER'S NAME
CHARLE F. LUM | | | | | | | | | | | | 14. MOTHER'S MAIDEN NAME
LILLIE M. FISH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | | | | | | | | | | | 16. SOCIAL SECURITY NO.
220-18-3143 | | | | | | | | | | | | 17. INFORMANT
MR. EUGENE W. MASSIE | | | | | | | | | | | | Address HAGERSTOWN MD. | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ingestion of sodium fluoride
9917
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last.
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Depression state | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | | | | | | | | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
Howard N. Weeks, M.D.
ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Howard N. Weeks, M.D. | | | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Hagerstown, Md.
Address (Street, city, town, or county) | | | | | | | | | | | | 3/28/66
DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | | | | | | | | | 22b. DATE THEREOF
3/29/66 | | | | | | | | | | | | 22c. NAME OF CEMETERY OR CREMATORY
REST HAVEN CEM. | | | | | | | | | | | | 22d. LOCATION (City, town, or country) (State)
HAGERSTOWN MD. | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR
W. J. Horne
ADDRESS Hagerstown, Md. | | | | | | | | | | | | 24a. REC'D BY REGISTRAR
MAR 31 1966 | | | | | | | | | | | | 24b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | | | | | |

000000

000000

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04451
04447

Item 9 Film 6574 5/21/66 mh

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY
WASHINGTON
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN
c. LENGTH OF STAY IN 1b
6 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
WASHINGTON COUNTY HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
WASHINGTON
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN
d. STREET ADDRESS
60 E. WASHINGTON ST.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
SAMUEL HARRISON McBETH | | 4. DATE OF DEATH
MARCH 11 19 66 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
DEC. 19, 1885 |
| 9. AGE (in years last birthday)
80 yrs. | | 10. IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED FREIGHT CONDUCTOR | | 10b. KIND OF BUSINESS OR INDUSTRY
RAILROAD | |
| 11. BIRTHPLACE (County & State, or foreign country)
FRANKLIN CO., PENNA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JAMES McBETH | | 14. MOTHER'S MAIDEN NAME
SOPHIE STRAYER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
705-10-5368 | |
| 17. INFORMANT
MRS. SUSAN BOWERMASTER SHIPPENSBURG, PENNA. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Emphysema
5-271
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/5/66 , 19 66 , to 3/11/66 , 19 66 , that (I) (we) last saw the deceased alive on 3/11/66 , 19 66 , and that death occurred at 11:45 p.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Howard N. Weeks M.D. | | 22b. DATE SIGNED
3/14/1966 | |
| 22c. PHYSICIAN'S NAME (Type)
HOWARD N. WEEKS M.D. | | 22d. ADDRESS
580 NORTHERN AVE. HAGERSTOWN, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
MARCH 15, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
SPRING HILL CEMETERY | | 23d. LOCATION (City, town or county) (State)
SHIPPENSBURG, PENNSYLVANIA | |
| 24. FUNERAL DIRECTOR
Charles Rouser | | 25a. REC'D BY REGISTRAR
MAR 16 1966 | |
| ADDRESS
HAGERSTOWN, MARYLAND | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

10000

10000

10000

10000

10000

10000

10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04452 CERTIFICATE OF DEATH 04448

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | |
| c. LENGTH OF STAY IN 1b <u>18 yrs.</u> | | d. STREET ADDRESS <u>2241 Briarcliff Drive</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Frank</u> Middle <u>Parker</u> Last <u>Mc Crow</u> | | 4. DATE OF DEATH
Month <u>March</u> Day <u>2</u> Year <u>1966</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 15, 1915</u> |
| 9. AGE (In years last birthday) <u>50</u> yrs. | | IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer (Corporation)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Refrigeration</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Gainesville, Florida</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John Carey Mc Crow</u> | | 14. MOTHER'S MAIDEN NAME <u>Lillian Parker</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) <u>No</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>264-18-3122</u> | |
| 17. INFORMANT <u>Mrs. J.P. McCrow</u> | | Address <u>Hagerstown, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon</u>
<u>1538</u> DUE TO
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1538</u> DUE TO
(c) <u>1538</u> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-25</u> , 19 <u>64</u> , to <u>3-2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3-2</u> 19 <u>66</u> , and that death occurred at <u>12:25</u> P.M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Dalton M. Welty</u> | | 22b. DATE SIGNED <u>3/3/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dalton M. Welty, M.D.</u> | | 22d. ADDRESS <u>998 Potomac Ave, Hagerstown, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>3/4/66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Wm. G. Horst</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH | | | | | | | | | |
|--|---------------------------|---|--|---|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Washington</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>
c. LENGTH OF STAY IN 1b <i>16-2</i>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Western Md State Hospital</i> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Md</i>
b. COUNTY <i>Pro Geo</i>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park, Md</i>
d. STREET ADDRESS <i>5214 Seminole St</i>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>HOWARD</i> Middle <i>S</i> Last <i>McDERMOTT</i> | | | 4. DATE OF DEATH
Month <i>3</i> Day <i>30</i> Year <i>1966</i> | | | | | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>8-12-02</i> | 9. AGE (in years last birthday) <i>63</i> yrs. | IF UNDER 1 YEAR
Months <i>3</i> Days <i>30</i> | | IF UNDER 24 HRS.
Hours <i>16</i> Min. <i>2</i> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto Mechanic</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Automobile</i> | | 11. BIRTHPLACE (County & State, or foreign country) <i>Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | |
| 13. FATHER'S NAME <i>Raymond Mc Dermott</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Rose Abergale</i> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>
(If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. <i>216 09 0717</i> | | 17. INFORMANT Address <i>Hospital Records Hagerstown Md</i> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CARCINOMATOSIS</i>
<i>161X</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CARCINOMA OF THE LARYNX</i>
DUE TO (c) <i>3 1/2 YEARS</i> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>3 YEARS</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <i>19</i> | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>10-4</i> , 19 <i>65</i> , to <i>3-30</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>3-30</i> 19 <i>66</i> , and that death occurred at <i>9:30</i> M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <i>Efren A. Ramirez</i> M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <i>3-31-66</i> | | |
| 22c. PHYSICIAN'S NAME (Type) <i>EFREN A. RAMIREZ</i> | | | | | 22d. ADDRESS <i>UMSH 1500 PENN. AVE., HAGERSTOWN, MD.</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE THEREOF
<i>Apr 2, 1966</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Evergreen Cemetery</i> | | | 23d. LOCATION (City, town or county) (State)
<i>Bladensburg, Md.</i> | | |
| 24. FUNERAL DIRECTOR ADDRESS
<i>F. Gasch's Sons Hyattsville, Md.</i> | | | | | 25a. REC'D BY REGISTRAR
<i>APR 4 1966</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

00000

00000

000

000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. (See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04454

04450

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN | | c. LENGTH OF STAY IN ID
3 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
WASHINGTON COUNTY HOSPITAL | | d. STREET ADDRESS
1650 BENNIE AVE. | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
EVELYN ARLENE MIDDLEKAUFF | | 4. DATE OF DEATH
Month Day Year
MARCH 12 19 66 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MARCH 1, 1916 |
| 9. AGE (In years last birthday)
50 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
REAL ESTATE AGENT | | 10b. KIND OF BUSINESS OR INDUSTRY
REALTOR | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
ROY CRAWFORD | | 14. MOTHER'S MAIDEN NAME
CORA BYERS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
214-09-9447 | |
| 17. INFORMANT
MR. E. ALDENE MIDDLEKAUFF | | Address HAGERSTOWN, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Overdosage of medication (Doriden, Elavil)
9718 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Depression state | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Howard N. Weeks | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
HOWARD N. WEEKS M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
MARCH 15, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
ROSE HILL CEMETERY | | 23d. LOCATION (City, town or county) (State)
HAGERSTOWN, MARYLAND | |
| 24. FUNERAL DIRECTOR
Charles E. Rager | | ADDRESS
HAGERSTOWN, MARYLAND | |
| 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| DATE
MAR 16 1966 | | | |

00000

00000

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|--|---|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
RURAL HAGERSTOWN | | | | c. LENGTH OF STAY IN 1b
1 YR. 6 MO. | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
FAHRNEY KEEDY HOME | | | | | | d. STREET ADDRESS
1816 HEISTERBORO RD. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) GRACE | | | First Middle Last
TOMLISON MILLER | | | 4. DATE OF DEATH
Month MARCH Day 21 Year 19 66 | | | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/7/1879 | | 9. AGE (in years last birthday)
86 s. | | IF UNDER 1 YEAR
Months 21 Days 19 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY
HOME | | 11. BIRTHPLACE (County & State, or foreign country)
VIRGINIA | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
SAMUEL W. HEADLEY | | | | | | 14. MOTHER'S MAIDEN NAME
ANNIE SANDY | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO.
218-38-0857D | | 17. INFORMANT
MR. HUNTER MILLER | | | Address HAGERSTOWN MD. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
4200 OUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
OUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 yrs. | |
| PART II. OTHER SIGNIFICANT CONDICTIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 10 , 19 66 , to March 21 , 19 66 , that (I) (we) last saw the deceased alive on March 21 , 19 66 , and that death occurred at 7 P.M. , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<i>[Signature]</i> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3/23/66 | | | |
| 22c. PHYSICIAN'S NAME (Type)
G. W. LeVan | | | | | | 22d. ADDRESS
Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
3/23/66 | | 23c. NAME OF CEMETERY OR CREMATORY
FAIRVIEW CEM. | | | | 23d. LOCATION (City, town or county) (State)
KEEDYSVILLE MD. | | | |
| 24. FUNERAL DIRECTOR
W. J. Harment, Hagerstown, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 29 1966 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

1821

WASH DC

WASHINGTON

WASHINGTON

WASHINGTON

20

21

22

23

24

25

26

27

28

29

30

U.S.A.

VERMONT

NEW

BRITAIN

AMERICAN

AMERICAN

WASHINGTON

WASHINGTON

20

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04456

CERTIFICATE OF DEATH

04452

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | c. LENGTH OF STAY IN 1b
life | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown 21-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington County Hoapital | | | | d. STREET ADDRESS
423 E. Wilson Blvd | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle WATKINS Last MINNICH | | | | 4. DATE OF DEATH
Month March Day 2 Year 19 66 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
Dec 9, 1909 | | 9. AGE (In years last birthday)
56 yrs. | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Funeral Director | | 10b. KIND OF BUSINESS OR INDUSTRY
Funeral Home | | 11. BIRTHPLACE (County & State, or foreign country)
Hagerstown, Md | | 12. CITIZEN OF WHAT COUNTRY?
 | |
| 13. FATHER'S NAME
Scott F. Minnich | | | | 14. MOTHER'S MAIDEN NAME
Mary J. Watkins | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
216-22-1962 | | 17. INFORMANT
Address
Mrs. Muriel Minnich Hag. Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Acute Myocardial Infarction
DUE TO (b) Arteriosclerotic Coronary Thrombosis
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 hours
3 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from March 2, 1966 , to March 2, 1966 , that (we) last saw the deceased alive on March 2, 1966 , and that death occurred at 3:45 P.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Dalton M. Welty | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3/3/66 | |
| 22c. PHYSICIAN'S NAME (Type)
Dalton M. Welty, M. D. | | | | 22d. ADDRESS
998 Potomac Ave., Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE THEREOF
3/5/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hag. Wash. Md. | |
| 24. FUNERAL DIRECTOR
Sdott F. Minnich & Son Hag, Md. | | | | 25a. REC'D BY REGISTRAR
MAR 8 1966 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04455

REQUIREMENT OF DEATH

25

04455

04455

04455

04455

04455

04455

04455

04455

04455

04455

04455

04455

04455

04455

04455

04455

04455

04455

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04457

CERTIFICATE OF DEATH

04453

| | | | | | | | | |
|---|--|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Keedysville | | | c. LENGTH OF STAY IN 1b
4 Yrs. | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Keedysville 21-1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rfd. 1 | | | | d. STREET ADDRESS
Rfd. 1 | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Albert Middle Edward Last Moats | | | | 4. DATE OF DEATH
Month March Day 13 Year 1966 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
Jan. 25, 1904 | | |
| 9. AGE (In years last birthday)
62 yrs. | | IF UNDER 1 YEAR
Months 1 Days 18 | | IF UNDER 24 HRS.
Hours 18 Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | | 10b. KIND OF BUSINESS OR INDUSTRY
Farming | | | 11. BIRTHPLACE (County & State, or foreign country)
Tilghmanton, Md. | | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | | |
| 13. FATHER'S NAME
William A. Moats | | | | 14. MOTHER'S MAIDEN NAME
Nannie R. Line | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No. | | | 16. SOCIAL SECURITY NO.
220-30-8981 | | 17. INFORMANT
Mrs. Leroy Reeder Keedysville Rfd. 1, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Corruptive heart failure
525X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cor pulmonale
DUE TO (c) Pulmonary fibrosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
37 years
3 years
30 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2-18- 19 66 , to 3-12- 19 66 , that (I) (we) last saw the deceased alive on 3-13- 19 66 , and that death occurred at 03:00 A.M. from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE
J. Secodari | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3-1-1966 | | |
| 22c. PHYSICIAN'S NAME (Type)
JOSEPH SECONDARI | | | | 22d. ADDRESS
Boonsboro Md | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3-15-66 | | 23c. NAME OF CEMETERY OR CREMATORY
Boonsboro Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Boonsboro, Md. | | |
| 24. FUNERAL DIRECTOR
John H. Bast, Jr. 112 N. Main St., Boonsboro, Md. | | | | 25a. REC'D BY REGISTRAR
MAR 17 1966 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | |

04453

STATE OF NEW YORK

04453

County of ...

City of ...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 1/65

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH </div> | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>4 yrs.</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 21-1
d. STREET ADDRESS <u>111 Winter St.</u> | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Malloya K (nmn) Moore</u> | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>30</u> Year <u>1966</u> | | | 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Feb. 8, 1927</u> | | 9. AGE (In years last birthday) <u>39</u> yrs.
IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Construction</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Glenncville, N.C.</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | 13. FATHER'S NAME
<u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME
<u>Rosella Moore Ellenberg</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>246-32-5029</u> | | 17. INFORMANT
<u>Mrs. M.K. Moore</u> | | Address
<u>111 Winter St. Hagerstown, Md.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>pneumococcal septicemia</u>
493X DUE TO (b) <u>pneumococcal pneumonia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>3 days</u> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from <u>3/29</u> , 19 <u>66</u> , to <u>death</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. | |
| 22a. SIGNATURE
<u>John C. Stauffer</u> | | 22b. DATE SIGNED
<u>APR 4 1966</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>John C. Stauffer, M. D.</u> | | 22d. ADDRESS
<u>Hagerstown, Md.</u> | | 22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>4/1/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rest Haven Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Hagerstown Md.</u> | | 24. FUNERAL DIRECTOR
<u>Wm. C. Host</u> | |
| 25a. REC'D BY REGISTRAR
<u>APR 4 1966</u> | | 25b. REGISTRAR'S SIGNATURE
<u>f Charles Judge</u> | | 25c. ADDRESS
<u>Rest Haven Funeral Chapel Hagerstown, Md.</u> | | 25d. DATE
<u>APR 4 1966</u> | | 25e. SIGNATURE
<u>f Charles Judge</u> | |

1954

1954

Received

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

of the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>04455</p> <p>04455</p> </div> </div> | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> | | | c. LENGTH OF STAY IN 1b
<u>24 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> <u>21-1</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>617 George St.</u> | | | | | d. STREET ADDRESS
<u>617 George St.</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>David</u> Middle <u>Kudghel</u> Last <u>Morningstar</u> | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>17</u> Year <u>19 66</u> | | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>March 23, 1904</u> | | 9. AGE (In years last birthday) <u>61</u> yrs.
IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Cab Driver</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Transportation</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Leetown, W. Va.</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>John David Morningstar</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Bessie A. Grubbs</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>234-22-6025</u> | | 17. INFORMANT
Address <u>Mrs. Richard Myers R # 5 Hagerstown, Md.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u>
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic heart disease</u>
DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerosis, cerebral and generalized involving especially popliteal vessels</u>
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u>
<u>1 year (certain)</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 4</u> , 19 <u>65</u> , to <u>March 17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>March 1</u> , 19 <u>66</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>W. T. Layman</u> | | | | | 22b. DATE SIGNED
<u>3/18/66</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>William T. Layman, M.D.</u> | | |
| 22d. ADDRESS
<u>100 Professional Arts Bldg. Hagerstown, Maryland</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>3/20/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rest Haven Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Hagerstown Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>W. G. Horst</u>
<u>Rest Haven Funeral Chapel</u> | | | | | 25a. REC'D BY REGISTRAR
<u>MAR 22 1966</u> | | 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | |

2624

452

1890

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death, should be filed with the State Dept. of Health.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04460

04456

| | | | | | | | | |
|---|--|---|--|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | c. LENGTH OF STAY IN lb
3 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gapland | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington County Hospital | | | | d. STREET ADDRESS
21 - 1 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First Hattie Middle Mae Last Moss | | | | 4. DATE OF DEATH March 21, 19 66 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 10, 1886 | | |
| 9. AGE (In years last birthday) 80 yrs. | | 10. IF UNDER 1 YEAR Months 1 Days 11 Hours Min. | | 11. IF UNDER 24 HRS. Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
Broad Run Fred. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
James Cockran | | | | 14. MOTHER'S MAIDEN NAME
Ida Reeder | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, up, or unknown) (If yes give war or dates of service)
No. | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mr. Roy Moss Rohrsersville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aggravated cardiac vascular disease
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of mesenteric vessels
DUE TO (c) Diabetes mellitus
INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
1 week
2 yrs. | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from March 15, 1966 to March 21, 1966 , that (I) (we) last saw the deceased alive on March 21, 1966 , and that death occurred at 6 P.M. from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE
G. W. Heelan | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED
March 23, 66 | | |
| 22c. PHYSICIAN'S NAME (Type)
G. W. Heelan | | | 22d. ADDRESS
Boonsboro, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3-24-66 | | 23c. NAME OF CEMETERY OR CREMATORY
Brownsville Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Brownsville, Md. | | |
| 24. FUNERAL DIRECTOR
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | 25a. REC'D BY REGISTRAR
MAR 24 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

70228

6032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|-------------------|--|--|--|--|--|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 04461 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL SHARPSBURG
c. LENGTH OF STAY IN 1b 37 YRS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WOBURN MANOR | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL SHARPSBURG
d. STREET ADDRESS WOBURN MANOR
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print)
CHARLES COURTENAY MYERS | | | First Middle Last | | | 4. DATE OF DEATH
MARCH 12 19 66 | | | Month Day Year | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JAN. 16, 1895 | | 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED OFFICAL | | | | 10b. KIND OF BUSINESS OR INDUSTRY
WHOLESALEERS | | 11. BIRTHPLACE (County & State, or foreign country)
UPSHUR, W. VIRGINIA | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
CHARLES M. MYERS | | | | | | 14. MOTHER'S MAIDEN NAME
ANNA MYERS | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO.
214-09-7966A | | 17. INFORMANT
MRS. MARGARET MYERS SHARPSBURG, MD. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis
DUE TO (c) Arteriosclerotic Cardio-Dis.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous myocardial infarction, Cardiac failure, Diabetes
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of form 18) | | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8 Feb 19 59 to Date , that (I) (we) last saw the deceased alive on 15 Jan 19 65 and that death occurred at 7A M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Richard T. Binford | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3/14/1966 | | | |
| 22c. PHYSICIAN'S NAME (Type)
RICHARD T. BINFORD M.D. | | | | | | 22d. ADDRESS
1135 POTOMAC AVE. HAGERSTOWN, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
MARCH 14, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
REST HAVEN CEMETERY | | 23d. LOCATION (City, town or county) (State)
HAGERSTOWN, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
Charles H. Rouse | | | | | | ADDRESS
HAGERSTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR
MAR 16 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

04553

04553

PORTLAND

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

79

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|---|--|--|---|---|--|---|--|---|--|
| 04462 CERTIFICATE OF DEATH 04458 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN | | | | c. LENGTH OF STAY IN 1b
1 DAY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
WASHINGTON COUNTY HOSPITAL | | | | | | d. STREET ADDRESS
507 S. POTOMAC ST. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
BILLY | | | First JOE | | | Last PAUL | | | 4. DATE OF DEATH
Month MARCH Day 20 Year 19 66 | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MARCH 19, 1966 | | 9. AGE (In years last birthday)
yrs. 17 | | IF UNDER 1 YEAR: Months 17 Days 17 Hours 17 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | | | 10b. KIND OF BUSINESS OR INDUSTRY
NONE | | 11. BIRTHPLACE (County & State, or foreign country)
WASHINGTON CO., MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
WILLIAM F. PAUL | | | | | | 14. MOTHER'S MAIDEN NAME
CARRIE N. WILLIAMS | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | (If yes give war or dates of service)
----- | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
MR. WILLIAM PAUL 507 S. POTOMAC ST. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hyaline Membrane
7620 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stenosis
DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
hour
hour | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from 19 April, 1966 to 20 April, 1966 , that (I) (we) last saw the deceased alive on 19 April, 1966 , and that death occurred at 5:12 M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Eldon G. Hoachlander | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3/21/66 | | | |
| 22c. PHYSICIAN'S NAME (Type)
ELDON G. HOACHLANDER M.D. | | | | | | 22d. ADDRESS
115 W. WASHINGTON ST. HAGERSTOWN, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE THEREOF
MARCH 22, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
ROSE HILL CEMETERY | | | 23d. LOCATION (City, town or county) (State)
HAGERSTOWN, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
Charles S. Kasper | | | | | | ADDRESS
HAGERSTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR
MAR 24 1966 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

1944

RECEIVED
JAN 10 1944



U.S. DEPARTMENT OF AGRICULTURE

PLANT

INDUSTRY

WILLIAM F. SMITH

CARLISLE W. WILLIAMS

WILLIAM F. SMITH, JR.

U.S. DEPARTMENT OF AGRICULTURE

BUREAU OF PLANT INDUSTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|----------------------------------|---|---|--|--|--|---|---|--|
| 04463 CERTIFICATE OF DEATH 04459 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN
c. LENGTH OF STAY IN 1b LIFE
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RT.#6 HAGERSTOWN | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN
d. STREET ADDRESS RT.#6 HAGERSTOWN
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
SAMUEL First HORST Middle PETRE Last | | | 4. DATE OF DEATH
Month MARCH Day 28 Year 66 | | | | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/24/1877 | 9. AGE (In years last birthday) 88 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED FARMER | | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN FARM | | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
GEORGE WASHINGTON PETRE | | | | | 14. MOTHER'S MAIDEN NAME
ELIZABETH HORST | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | 16. SOCIAL SECURITY NO.
217-16-2604 | | 17. INFORMANT
MRS. CLARA R. PETRE Address RT.#6 Hagerstown MD. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 days
5 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/23 , 19 66 to 3/28 , 19 66 , that (I) (we) last saw the deceased alive on 3/27 , 19 66 , and that death occurred at 1450 M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Donald E. Martin | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3/29/66 | | |
| 22c. PHYSICIAN'S NAME (Type)
Donald E. Martin M.D. | | | | | 22d. ADDRESS
418 N. Potomac St. Hagerstown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
3/31/66 | | 23c. NAME OF CEMETERY OR CREMATORY
REST HAVEN CEM. | | | 23d. LOCATION (City, town or county) (State)
HAGERSTOWN MD. | | |
| 24. FUNERAL DIRECTOR
W. J. Harment, Hagerstown, Md. | | | | | 25a. REC'D BY REGISTRAR
APR 4 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

011110

011110

011110

011110

011110

011110

011110

011110

011110

011110

011110

011110

011110

011110

011110

Myocardial Infarction
Atherosclerotic Heart Disease 2/10/50

3/23 66 3/28 W

3/23

3/23 W

Downs 3/23/50

011110

011110

011110

011110

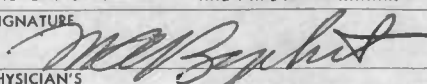
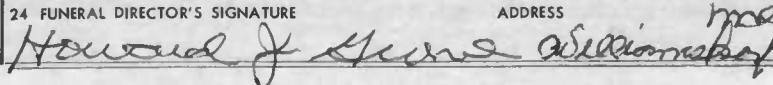
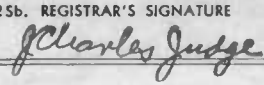
011110

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04460

| | | | | | | | |
|---|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairplay
d. STREET ADDRESS 21-1
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Joseph Russell Reichard | | 4. DATE OF DEATH
March 13 19 66 | | | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
SEPT. 13. 1888 | 9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR: Months 77 Days 77 Hours 77 Min. 77 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farming | | 10b. KIND OF BUSINESS OR INDUSTRY
FAIR PLAY MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
DAVID W REICHARD | | | 14. MOTHER'S MAIDEN NAME
AMRY A COFFMAN | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO.
219.36.2808 | | 17. INFORMANT
VAL B REICHARD | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO 331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis
DUE TO (c) 10 yrs
12 yrs | | | | INTERVAL BETWEEN ONSET AND DEATH
10 yrs
12 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
none | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) observed attended the deceased from 1.8.59 to 3.13.66, 19....., that (I) was saw the deceased alive on 3.13.66, 19....., and that death occurred at 8:30 PM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
 | | | | 22b. DATE SIGNED
3.14.66 | | | |
| 22c. PHYSICIAN'S NAME (Type)
M. E. Byrkit, M. D. | | | | 22d. ADDRESS
Williamsport, Maryland 21795 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
3.17.66 | | 23c. NAME OF CEMETERY OR CREMATORY
GREEN LAWN | | | |
| 23d. LOCATION (City, town or county)
WILLIAMSPORT WASHINGTON MD | | | | (State) | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
 | | | | 25a. REC'D BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04110

04110

Washington
Maryland
Virginia
T. Davis
Baltimore
Harrison

Washington County Hospital

Joseph Marshall
Richard
March 13

State
Date
Sept. 1, 1958

FAIR GLAY HAYLAND
U.S.A.

DAVID W. RICHARD

W. RICHARD
210.25.08
VAC. 8 RICHARD 400 SHWITZ AVE.
H. RICHARDSON

2

3.13.66
1.8.58
3.13.66

1.8.58

3.13.66
3.13.66

Williamson, Maryland 21777
A. T. Davis

WILLIAMSON WASHINGTON
GREEN LAKE
3.13.66

WILLIAMSON WASHINGTON
GREEN LAKE
3.13.66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04461

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> <u>MARYLAND</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>
c. LENGTH OF STAY IN lb <u>2 Days</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>
d. STREET ADDRESS <u>232 Balto Avenue</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Jenny</u>
5. SEX <u>Female</u>
6. COLOR OR RACE <u>White</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Sweden</u>
13. FATHER'S NAME <u>Sven Anderson</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>
16. SOCIAL SECURITY NO. <u>None</u> | | 4. DATE OF DEATH
<u>March 6, 1966</u>
8. DATE OF BIRTH <u>Sept. 13, 1880</u>
9. AGE (In years last birthday) <u>85</u>
11. BIRTHPLACE (County & State, or foreign country) <u>U S A</u>
14. MOTHER'S MAIDEN NAME <u>Louisa Peterson</u>
17. INFORMANT <u>William Reitz, 232 Balto Ave., Cumberland Md</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cerebral thrombosis & hemiplegia</u>
<u>332X</u> DUE TO (b) <u>Arteriosclerosis, general</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u>
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | | 21. I certify that (I) (this hospital) attended the deceased from <u>March 4, 1966</u> to <u>March 6, 1966</u> , that (I) (we) last saw the deceased alive on <u>March 6, 1966</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.
22a. SIGNATURE <u>Victor L. Ramos</u> M.D.
22c. PHYSICIAN'S NAME (Type) <u>Victor L. Ramos, M.D.</u>
22b. DATE SIGNED <u>March 6, 1966</u>
22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>
23b. DATE THEREOF <u>Mar. 9, 1966</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>
23d. LOCATION (City, town or county) (State) <u>Cumberland, Maryland</u> | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u> ADDRESS <u>230 Balto Ave. Cumberland Md</u>
25a. REC'D BY REGISTRAR <u>MAR 8 1966</u>
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14551

14551

March 1, 1910

July

July

Sept. 19, 1910

Guests

General Phosphate Company

Phosphate Company

March 1, 1910

March 1, 1910

March 1, 1910

March 1, 1910

March 1, 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04466 | | | | | | | | | |
|--|--|--|--------------------------------------|---|---|---|---------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | | c. LENGTH OF STAY IN 1b <u>7 Mo.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Rural 01-2</u> | | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Md State Hosp.</u> | | | | | d. STREET ADDRESS <u>Rt. 3, Bedford Road</u> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>MARY ETHEL</u> First <u>RICE</u> Middle <u>R</u> Last <u>RICE</u> | | | | | 4. DATE OF DEATH <u>MARCH 24 1966</u> Month <u>March</u> Day <u>24</u> Year <u>1966</u> | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6/24/1890</u> | | 9. AGE (In years last birthday) <u>75</u> yrs. | |
| | | | | | | | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Clean home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Allegany, Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Richard C. Levick</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Laura Matthews</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Russell L. Rice, Cumberland Md.</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u>
<u>332x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL THROMBOSIS RT HEMIPLEGIA 9 MOS</u>
DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS YEARS</u> | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETIS MELITUS</u> | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8-18-1965</u> to <u>3-24-1966</u> , that (I) (we) last saw the deceased alive on <u>3-24-1966</u> , and that death occurred at <u>10:20</u> M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Eugen G. Ramirez</u> M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>3/24/66</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>EUGEN A. RAMIREZ</u> | | | | | 22d. ADDRESS <u>1500 PENN. AVE, HAGERSTOWN, MD.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>3/27/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Morn. Park</u> | | 23d. LOCATION (City, town or county) (State) <u>Cumberland, Md</u> | | | |
| 24. FUNERAL DIRECTOR <u>Byron Right, Cumberland, Md</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | 25c. DATE <u>MAR 30 1966</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> <p>1</p> <p>M</p> </div> <div style="text-align: center;"> <p>04467</p> <p>04463</p> </div> | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| <div style="text-align: center;"> <p>1. PLACE OF DEATH</p> <p>a. COUNTY WASHINGTON MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 30 YRS.</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 15 S. CLEVELAND AVE.</p> </div> | | | | | | | | | |
| <div style="text-align: center;"> <p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE MARYLAND b. COUNTY WASHINGTON</p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 21-1</p> <p>d. STREET ADDRESS 15 S. CLEVELAND AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> </div> | | | | | | | | | |
| <div style="text-align: center;"> <p>3. NAME OF DECEASED (Type or print)</p> <p>First BERTHA Middle MAY Last RIDENOUR</p> <p>4. DATE OF DEATH MARCH 1 1966</p> </div> | | | | | | | | | |
| <div style="text-align: center;"> <p>5. SEX FEMALE 6. COLOR OR RACE WHITE</p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH APRIL 24, 1885</p> <p>9. AGE (In years last birthday) 80 10. IF UNDER 1 YEAR IF UNDER 24 HRS.</p> <p>11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.</p> </div> | | | | | | | | | |
| <div style="text-align: center;"> <p>13. FATHER'S NAME OTHO J. HAMMOND</p> <p>14. MOTHER'S MAIDEN NAME EMILY C. BARGER</p> </div> | | | | | | | | | |
| <div style="text-align: center;"> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 217-52-5754</p> <p>17. INFORMANT GEORGE RIDENOUR III 15 S. CLEVELAND AVE.</p> </div> | | | | | | | | | |
| <div style="text-align: center;"> <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden massive hemorrhage, probably pulmonary INTERVAL BETWEEN ONSET AND DEATH minutes</p> <p>4500 DUE TO (b) Arteriosclerotic vascular disease Ap. 5 yrs.</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerosis.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Upper respiratory infection.</p> </div> | | | | | | | | | |
| <div style="text-align: center;"> <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p> <p>20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) HAGERSTOWN (County) MARYLAND (State) MARYLAND</p> </div> | | | | | | | | | |
| <div style="text-align: center;"> <p>21. I certify that (I) (this hospital) attended the deceased from March 1, 1966 to March 1, 1966, that (I) (we) last saw the deceased alive on March 1, 1966, and that death occurred at 6:00 P.M. from the causes and on the date stated above.</p> </div> | | | | | | | | | |
| <div style="text-align: center;"> <p>22a. SIGNATURE J. Walter Layman 22b. DATE SIGNED 3/2/1966</p> <p>22c. PHYSICIAN'S NAME (Type) J. WALTER LAYMAN M.D. 22d. ADDRESS PROFESSIONAL ARTS. BLDG. HAG. MD.</p> </div> | | | | | | | | | |
| <div style="text-align: center;"> <p>23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 3/4/1966</p> <p>23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY 23d. LOCATION (City, town or county) HAGERSTOWN, MARYLAND (State) MARYLAND</p> </div> | | | | | | | | | |
| <div style="text-align: center;"> <p>24. FUNERAL DIRECTOR Charles M. Lange 25a. REC'D BY REGISTRAR Charles Judge</p> <p>25b. REGISTRAR'S SIGNATURE Charles Judge</p> </div> | | | | | | | | | |

04463

1001

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

30 APR

WASHINGTON

12 P. M. APR 30

12 P. M. APR 30

WASHINGTON

WASHINGTON

WASHINGTON

30 APR

WASHINGTON

12 P. M. APR 30

12 P. M. APR 30

WASHINGTON

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1
(M)

04468

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04468

| | | | | | | | |
|---|--|--|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Eckhart</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Western Maryland State Hospital</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Bert</u> Middle <u>ARTHUR</u> Last <u>Rizer</u> | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>23</u> Year <u>1966</u> | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Jan. 29, 1906</u> | |
| 9. AGE (In years last birthday)
<u>60</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Maintenance Man</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Allegany Co., Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U S A</u> | |
| 13. FATHER'S NAME
<u>Arthur G. Rizer</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Anne Davis</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>WW 2</u> | | 17. INFORMANT
<u>Mrs. Myrtle Johnson</u> | | Address
<u>Eckhart, Maryland</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Lobular pneumonia</u>
<u>1930</u> DUE TO (b) <u>Oligodendroglioma of brain</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>5 years</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 21, 1964</u> , to <u>March 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>March 23, 1966</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Victor L. Ramos</u> | | | | 22b. DATE SIGNED
<u>March 23, 1966</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>VICTOR L. RAMOS, M.D.</u> | |
| 22d. ADDRESS
<u>Western Md. State Hospital Hagerstown, Maryland</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | | |
| 23b. DATE THEREOF
<u>March 26, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Eckhart Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Eckhart, Maryland</u> | | 25a. REC'D BY REGISTRAR
<u>John J. Hafer</u> | |
| 24. FUNERAL DIRECTOR
<u>John J. Hafer, 230 Balto. Ave., Cumberland, Md.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE
<u>MAR 29 1966</u> | | | |

1910

1910

March 23, 1910

Best
Barnum
Type

Jan 23rd 1910

2 year
3 days

Chondrodiplosis of brain
lobular pneumonia

March 23, 1910
Victor & James, m.d.
New York, N.Y.

March 23, 1910
Victor & James, m.d.
New York, N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G375 3/31/66 mh

CERTIFICATE OF DEATH

04469

04465

| | | | | | | | |
|---|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Wash. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | c. LENGTH OF STAY IN 1b
50 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown 21-1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
542 Salem Ave. | | | | d. STREET ADDRESS
542 Salem Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ALICE Middle LOUISE Last ROWE | | | | 4. DATE OF DEATH
Month March Day 18 Year 1966 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1885
Nov. 3, 1875 | 9. AGE (In years last birthday)
80 yrs. | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
State Line, Penna. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
George W. Sellers | | | | 14. MOTHER'S MAIDEN NAME
Mary Ellen Rummel | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Address
Melvin E. Rowe, Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Arteriosclerotic Heart Disease
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiac vascular Disease
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 years
15 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Residuals Cerebral Thrombosis (Pontine Branch) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11-17 , 19 62 to 3-18 , 19 66 , that (I) (we) last saw the deceased alive on 3-18 19 66 , and that death occurred at 9 P. M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Dalton M. Welty | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type)
Dalton M. Welty, M. D. | |
| 22d. ADDRESS
998 Potomac Avenue | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3-22-66 | | 23c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown, Md. | |
| 24. FUNERAL DIRECTOR
Minnich Funeral Home, Hagerstown, Md. | | | | 25a. REC'D BY REGISTRAR
MAR 24 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2020

634

• 4925 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

04470

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04466

| | | | | | | | | |
|---|--|--|--|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Hagerstown | | | c. LENGTH OF STAY IN 1b
4 Yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Point of Rocks | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Gateway Convalescent Home | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Charles Milton Sandusky | | | | 4. DATE OF DEATH
Month Day Year
March 13, 19 66 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Jan. 19, 1887 | | |
| 9. AGE (In years last birthday)
79 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
1 24 | | IF UNDER 24 HRS.
Hours Min.
1 24 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Trackman | | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | | 11. BIRTHPLACE (County & State, or foreign country)
Jasper Co. Iowa | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
James Sandusky | | | | 14. MOTHER'S MAIDEN NAME
Letitia Harper | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No. | | | 16. SOCIAL SECURITY NO.
723-09-0621 | | 17. INFORMANT
Stanley E. Sandusky, Gapland, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO (c) ARTEROSCLEROSIS, GEN. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Minutes
Yes.
Yes. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 15 June, 1963 to 13 March, 1966 , that (I) (we) last saw the deceased alive on 13 March 1966 , and that death occurred at 5:30 AM , from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE
[Signature] | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
14 March 1966 | | |
| 22c. PHYSICIAN'S NAME (Type)
W. N. FENDER | | | | 22d. ADDRESS
218 N. Potomac St., Hagerstown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3-16-66 | | 23c. NAME OF CEMETERY OR CREMATORY
Methodist Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Taylortown, Virginia | | |
| 24. FUNERAL DIRECTOR
John H. Bast, Jr. 112 N. Main St., Boonsboro, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAR 17 1966 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

04100

04100

1. Name of the person: [illegible]
2. Date of birth: [illegible]
3. Place of birth: [illegible]

4. Date of death: [illegible]
5. Cause of death: [illegible]
6. Date of burial: [illegible]
7. Place of burial: [illegible]

8. Name of the person: [illegible]
9. Date of birth: [illegible]
10. Place of birth: [illegible]

11. Date of death: [illegible]
12. Cause of death: [illegible]
13. Date of burial: [illegible]
14. Place of burial: [illegible]

15. Name of the person: [illegible]
16. Date of birth: [illegible]
17. Place of birth: [illegible]

18. Date of death: [illegible]
19. Cause of death: [illegible]
20. Date of burial: [illegible]
21. Place of burial: [illegible]

1. Name of the person: [illegible]
2. Date of birth: [illegible]
3. Place of birth: [illegible]
4. Date of death: [illegible]
5. Cause of death: [illegible]
6. Date of burial: [illegible]
7. Place of burial: [illegible]
8. Name of the person: [illegible]
9. Date of birth: [illegible]
10. Place of birth: [illegible]
11. Date of death: [illegible]
12. Cause of death: [illegible]
13. Date of burial: [illegible]
14. Place of burial: [illegible]
15. Name of the person: [illegible]
16. Date of birth: [illegible]
17. Place of birth: [illegible]
18. Date of death: [illegible]
19. Cause of death: [illegible]
20. Date of burial: [illegible]
21. Place of burial: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04467 | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Md. b. COUNTY Washington | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | c. LENGTH OF STAY IN 1b
5 Weeks | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cascade | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Washington County Hospital | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Walter Clarence Schildt | | | 4. DATE OF DEATH
Month Day Year
March 23 1966 | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1/2/1879 | | 9. AGE (in years last birthday)
87 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Sabillasville, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles W. Schildt | | | | | 14. MOTHER'S MAIDEN NAME
Catherine McClain | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
173-03-3129 | | 17. INFORMANT
Mrs. Rayburn Needy, Cascade Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CANCER OF PANCREAS
157X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Narrow Atherosclerotic Heart Disease | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 WEEKS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-11, 1966, to March 23, 1966 that (I) (we) last saw the deceased alive on 3-23, 1966, and that death occurred at 8:20 PM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
E. R. Laddizabal M.D. | | | | 22b. DATE SIGNED
3-24-66 | | 22c. PHYSICIAN'S NAME (Type)
E. R. Laddizabal M.D. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
3/27/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Hill | | 23d. LOCATION (city, town or county) (State)
Waynesboro, Franklin Co., Pa. | | |
| 24. FUNERAL DIRECTOR
Walter Z. Shore | | | | 25a. REC'D BY REGISTRAR
MAR 28 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

04485

CERTIFICATE OF DEATH

1978

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, CITY OF NEW YORK, OR IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF NEW YORK, OR IN THE OFFICE OF THE REGISTRAR OF DEATHS, STATE OF NEW YORK.

NAME OF DECEASED: *John Doe*
DATE OF DEATH: *1978*
PLACE OF DEATH: *New York City*

CAUSE OF DEATH: *Heart Disease*
MANNER OF DEATH: *Natural*

DATE OF BIRTH: *1920*
PLACE OF BIRTH: *New York City*

DATE OF DEATH: *1978*
PLACE OF DEATH: *New York City*

DATE OF DEATH: *1978*
PLACE OF DEATH: *New York City*

DATE OF DEATH: *1978*
PLACE OF DEATH: *New York City*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04472

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04468

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown
c. LENGTH OF STAY IN 1b
Hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington County Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Boonsboro (Mother)
d. STREET ADDRESS
21 - 1
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Baby Girl Secondari | | 4. DATE OF DEATH
March 10, 19 66 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 10, 1966 |
| 9. AGE (In years lost birthday) yrs.
2 | | 10. IF UNDER 1 YEAR
Months Days Hours Min.
2 20 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (County & State, or foreign country)
Hagerstown, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Joseph Secondari | | 14. MOTHER'S MAIDEN NAME
Anna Sepling | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Dr. Joseph Secondari, | | Address
N. Main St. Boonsboro, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) premature c. atelectasis
7625- DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) pneumonia
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
last |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 3/10, 1966 , to 3/10, 1966 that (I) (we) last saw the deceased alive on 3/10, 1966 , and that death occurred at 6:50 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
H. D. Bowman, M.D. | | 22b. DATE SIGNED
3/11/66 | |
| 22c. PHYSICIAN'S NAME (Type)
H. D. Bowman, M.D. | | 22d. ADDRESS
318 N. POTOMAC ST. HAGERSTOWN, MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
3-11-66 | 23c. NAME OF CEMETERY OR CREMATORY
Boonsboro Cemetery | 23d. LOCATION (City or Town) (County) (State)
Boonsboro, Md. |
| 24. FUNERAL DIRECTOR
John H. Bast, Jr. 112 N. Main St., Boonsboro, Md. | | 25a. REC'D BY REGISTRAR
MAR 17 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

20120

RECORD OF DEATH

1912

1

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RELATIONSHIP

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|---|---|---|---|---|---|---|-----------------------------------|
| 04473 | | | | | 04469 | | | | |
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | c. LENGTH OF STAY IN 1b
20 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown 21-1 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
31 Coffman Ave. | | | | | d. STREET ADDRESS
31 Coffman Ave. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Fannie Elizabeth Shackelford | | | 4. DATE OF DEATH
Month Day Year
March 8 19 66 | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 29 1889 76 yrs. | | 9. AGE (In years last birthday) IF UNDER 1 YEAR
Months Days Hours Min.
3 7 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (County & State, or foreign country)
Porterstown Md. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Christopher Mongan | | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Dunn | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT 105 Allen Ave. Halfway
Mr. Leonard W. Shackelford Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary insufficiency
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive and Atherosclerotic heart disease
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Atherosclerosis, cerebral and generalized | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
9 hours
4 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 3, 1966, to March 8, 1966, that (I) (we) last saw the deceased alive on March 7, 1966, and that death occurred at 3:30 AM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
W. T. Fayman | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
March 8, 1966 |
| 22c. PHYSICIAN'S NAME (Type)
William T. Fayman, M.D. | | | | | 22d. ADDRESS
100 Professional Arts Bldg.
Hagerstown, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
March 11-66 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. View Cemetery | | 23d. LOCATION (City, town or county) (State)
Sharpsburg Maryland | | | |
| 24. FUNERAL DIRECTOR
Albert L. Leaf Williamsport Maryland | | | | | 25a. REC'D BY REGISTRAR
MAR 10 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

00100

17

W. J. Lee

MAR 10 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04474

CERTIFICATE OF DEATH

04470

| | | | | | | | |
|--|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Maugensville</u> | | c. LENGTH OF STAY IN 1b
<u>13 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Smithsburg, Md</u> <u>21-</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Mennonite Old Folks Home</u> | | | | d. STREET ADDRESS
<u>R # 2</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>DANIEL C. SHANK</u> | | | | 4. DATE OF DEATH
Month <u>Mar.</u> Day <u>18</u> Year <u>1966</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 4, 1884</u> | 9. AGE (In years last birthday)
<u>81</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Dairy</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Retired</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Wash Co</u>
<u>Nr. Greensburg, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>David Shank</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>CHARA Miller</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO. <u>A</u>
<u>215-26-7815</u> | | 17. INFORMANT
Address <u>Penrose Penner, R # 2, Smithsburg, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
<u>4221</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO
(c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 years</u>
<u>10 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec.</u> , 19 <u>65</u> , to <u>Mar. 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Mar. 18</u> , 19 <u>66</u> , and that death occurred at <u>7:30 M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>[Signature]</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>Mar. 19, 1966</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. E. W. Ditto, Jr.</u> | | | | 22d. ADDRESS
<u>215 W. Washington St., Hagerstown, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>3/22/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Millers Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Leitersburg Wash Co Md</u> | |
| 24. FUNERAL DIRECTOR
<u>Hagerstown</u>
<u>A. K. Coffman Funeral Home, Inc</u>
<u>Hagerstown, Md.</u> | | | | 25a. REC'D BY REGISTRAR
<u>MAR 22 1966</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

0520

453

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|----------------------------------|---|--|---|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> | | | c. LENGTH OF STAY IN 1b
<u>1 Day</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> <u>21-1</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Washington County Hospital</u> | | | | | d. STREET ADDRESS
<u>633 West Washington St</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>RUTH</u> Middle <u>ANN</u> Last <u>SLYE</u> | | | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>8</u> Year <u>1966</u> | | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>March 7 1966</u> | | 9. AGE (In years last birthday) <u>1</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Infant</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Hagerstown Washington Co MD</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Simon H. Slye</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Josephine Wolf</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Simon H. Slye 633 W. Washington St</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Abdominal - bleeding</u>
<u>7600</u> DUE TO (b) <u>Tentorial Rupture</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>24 hrs</u>
<u>24 hrs</u> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> , 19 <u>66</u> , to <u>3/8</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/8</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Richard A. Young</u> | | | | | 22b. DATE SIGNED
<u>3/11/66</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Richard A. Young</u> | | | | | 22d. ADDRESS
<u>14000s Farm, Md</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 23b. DATE THEREOF
<u>3/10/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Roose Hill Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Hagerstown Wash Co Md</u> | | |
| 24. FUNERAL DIRECTOR
<u>Hagerstown</u>
<u>Andrew K. Coffman Funeral Home Inc</u> | | | | | 25a. REC'D BY REGISTRAR
<u>MAR 14 1966</u> | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | |

171120

RECEIVED 10 JAN 1964

171120



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|------------------|--|-------------------------|--|---|--|------------------------------|---|---|
| 04476 | | | | | 04472 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | |
| a. COUNTY | | WASHINGTON | | | a. STATE | | MARYLAND | | |
| | | MARYLAND | | | b. COUNTY | | WASHINGTON | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | |
| HAGERSTOWN | | | 1 DAY | | RURAL HAGERSTOWN | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| WASHINGTON COUNTY HOSPITAL | | | | | R.D.# 2 WESTERN PIKE | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | | Middle | Last | | 4. DATE OF DEATH | | Month |
| MARY | | FELICIA | | SMITH | | MARCH | | 22 | 19 66 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | B. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| FEMALE | WHITE | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | OCT. 20, 1964 | | 1 yrs. 5 17 | | Months | Days |
| | | | | | | | | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| NONE | | NONE | | WASHINGTON CO., MARYLAND | | | U.S.A. | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| VINCENT P. SMITH | | | | | CAROLYN ANDREWS | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| NO | | NONE | | DR. VINCENT SMITH R.D.# 2 WESTERN PIKE | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vascular shock | | | | | | | | | hrs |
| 7562 DUE TO Hemorrhagic infarction of small bowel | | | | | | | | | 8 hrs |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Internal hernia | | | | | | | | | |
| DUE TO Merrkles diverticulum with congenial adhesive band | | | | | | | | | 17 mo |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| | | none | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| Hour a.m. none 19 p.m. | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | none | | - | | - | - |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 20, 1964, to Mar 22, 1966, that (I) (we) last saw the deceased alive on Mar 22, 1966, and that death occurred at A M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| Harold R. Tritch Jr. M.D. | | | | | M.D. | | 3/23/1966 | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | |
| HAROLD R. TRITCH JR. M.D. | | | | | 302 N. POTOMAC ST., HAGERSTOWN, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) (State) | | | |
| BURIAL | | MARCH 24, 1966 | | CEDAR LAWN CEMETERY | | WASHINGTON CO., MARYLAND | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Charles M. Ruyter | | | | | HAGERSTOWN, MARYLAND | | MAR 28 1966 | | |

1176

1176

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|------------------------|-------------------------------|--|--|---|--|---|--|
| 04477
CERTIFICATE OF DEATH | | | | | 04473 | | | | |
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 3 wks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Penna. b. COUNTY Franklin
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waynesboro
d. STREET ADDRESS 226 Park St.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Elder S Stoner | | | 4. DATE OF DEATH March 4 1966 | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 22, 1886 | | 9. AGE (In years last birthday) 79 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner - machine shop | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Washington Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Jacob Stoner | | | | 14. MOTHER'S MAIDEN NAME Sarah Whitmore | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. 173-03-3575A | | 17. INFORMANT Mr. H. Merle Creager Address Waynesboro, Penna. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) General Cerebral Sclerosis | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 20, 1966, to 3/4, 1966, that (I) (we) last saw the deceased alive on 3/4, 1966, and that death occurred at 11 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE J. H. Beagle | | | | 22b. DATE SIGNED 3/4/66 | | 22c. PHYSICIAN'S NAME (Type) J. H. Beagle | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 3/6/66 | | 23c. NAME OF CEMETERY OR CREMATORY Harbaugh Cemetery | | 23d. LOCATION (City, town or county) (State) Franklin Co., Penna. | |
| 24. FUNERAL DIRECTOR Walter J. Gatz | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |
| Waynesboro, Penna. | | | | DATE MAR 8 1966 | | | | | |

1944

1944

•

•

•

•

•

•

•

•

•

•

•

0 1 0 0 0 0

0 1 0 0 0 0



14



1/2

1/2

0 1 0 0 0 0

2

1

(M)

MD
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04478

CERTIFICATE OF DEATH

04474

| | | | | | | | |
|---|--|--|--|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE PENNA b. COUNTY FULTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN MD. | | | c. LENGTH OF STAY IN 1b
3WKS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
WARFORDSBURG PENNA. 75-3 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
WASHINGTON COUNTY HOSPITAL | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
CATHARINE BELLE STULTZ | | | | 4. DATE OF DEATH
Month Day Year
3 13 19 66 | | | |
| 5. SEX
F | | 6. COLOR OR RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JUNE 7 1893 | |
| 9. AGE (In years last birthday) yrs.
72 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
LOCK HAVEN PENNA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN F SARGEN | | | | 14. MOTHER'S MAIDEN NAME
MAUDE HINLEY | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT Address
WILLIAM & C STULTZ WARFORDSBURG PENNA | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolus, massive
466X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebothrombosis, left leg
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Right hemicolectomy for polyposis 3-8-66 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 min.
48 hrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-2 , 19 66 , to 3-13 , 19 66 that (I) (we) last saw the deceased alive on 3-13 , 19 66 and that death occurred 6:30 P , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>John H. Kehne M.D.</i> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3-16-66 | |
| 22c. PHYSICIAN'S NAME (Type)
John H. Kehne, M.D. | | | | 22d. ADDRESS
1229 Ravenwood Hgts., Hagerstown, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
3.17.66 | | 23c. NAME OF CEMETERY OR CREMATORY
PRESBYTERIAN | | 23d. LOCATION (City or Town) (County) (State)
WARFORDSBURG FULTON PA. | |
| 24. FUNERAL DIRECTOR ADDRESS
<i>Howard J. Hogue Hagerstown Md</i> | | | | 25a. REC'D BY REGISTRAR
MAR 22 1966 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04471

04471

FULTON

PENNA

WASHINGTON

HARRISBURG PENNA.

JANE

LIBERTY TOWNSHIP

WASHINGTON COUNTY HOSPITAL

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04479

04475

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Wash. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington County Hospital | | d. STREET ADDRESS
1314 Potomac Ave. | |
| 3. NAME OF DECEASED (Type or print)
First VELORA Middle VIRGINIA Last SWAUGER | | 4. DATE OF DEATH
Month March Day 12 Year 19 66 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 1, 1909 |
| 9. AGE (In years last birthday)
56 yrs. | | IF UNDER 1 YEAR
Months 3 Days 21 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
teacher | | 10b. KIND OF BUSINESS OR INDUSTRY
Board of Educat. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Jennings, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
William E. Swauger | | 14. MOTHER'S MAIDEN NAME
Lula Belle Hoover | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
059-22-4238 | |
| 17. INFORMANT
Ralph Swauger, Hagerstown, Md | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1958 to Mar-12, 1966 that (I) (we) last saw the deceased alive on Mar 12 19 66 , and that death occurred at 3:30 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Lloyd A. Hoffmann M.D. | | 22b. DATE SIGNED
3/13/66 | |
| 22c. PHYSICIAN'S NAME (Type)
Lloyd A. Hoffmann | | 22d. ADDRESS
214 N. Potomac St. Hagerstown | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE THEREOF
3-15-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Grantsville Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Grantsville, Md. | |
| 24. FUNERAL DIRECTOR
Minnich Funeral Home, Hagerstown, Md. | | 25a. REC'D BY REGISTRAR
MAR 16 1966 | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04137

CERTIFICATE OF BIRTH

04137

State of Virginia

Washington

Washington

10 years

Washington

1910

Washington County, Virginia

March 12

Washington

Virginia

May 1, 1900

White

Board of Health, Washington, D.C.

Teacher

John B. B. B.

William J. B. B.

John B. B. B.

02-22-123

No

John B. B. B.

02-22-123

No

John B. B. B.

02-22-123

No

John B. B. B.

02-22-123

No

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 04480 | | | | | | | | | |
| 04476 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Washington County Hospital</u> | | | | | d. STREET ADDRESS
<u>1631 Salem Ave.</u> | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Jeffrey</u> Middle <u>Lynn</u> Last <u>Swope</u> | | | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>31</u> Year <u>1966</u> | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Feb. 10, 1966</u> | | 9. AGE (in years last birthday)
<u>7</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Hagerstown, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Larry Richard Swope</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Cheryl Darlene Trumpower</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Mr. L.R. Swope 1631 Salem Ave. Hagerstown, Md.</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u>
<u>490X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aspiration</u>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Ectodermal dysplasia</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u>
<u>Sudden</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a.m. _____ p.m. _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/10/66</u> , 19 <u>66</u> , to <u>3/31/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/31/66</u> , 19 <u>66</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Howard N. Weeks, M.D.</u> | | | | | 22b. DATE SIGNED
<u>4/1/66</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Howard N. Weeks, M.D.</u> | | | | | 22d. ADDRESS
<u>580 Northern Avenue Hagerstown, Maryland</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>4/2/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rest Haven Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Hagerstown Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Wm. C. Norton</u> | | | | | 25a. REC'D BY REGISTRAR
<u>APR 4 1966</u> | | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | | | | | | | | |

4470

100

[Faint, mostly illegible text covering the main body of the page, possibly bleed-through from the reverse side.]

W. C. Hart

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

1
FOR STATE
HEALTH DEPT.

M

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04481

04477

| | | | |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>
c. LENGTH OF STAY IN 1b <u>Life</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Washington</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u>
d. STREET ADDRESS <u>111 N. High St.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Etta</u> Middle <u>May</u> Last <u>Troxell</u> | | 4. DATE OF DEATH
Month <u>March</u> Day <u>25</u> Year <u>1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 26, 1883</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR
Months <u>2</u> Days <u>1</u> | IF UNDER 24 HRS.
Hours <u>1</u> Min. <u>2</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George French</u> | | 14. MOTHER'S MAIDEN NAME <u>Carrie Everhart</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs. Beatrice Showe</u> | | Address <u>Funkstown, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Occlusion of Right Coronary Artery</u>
4201
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>
DUE TO (c) <u>Coronary Arteriosclerosis</u>
INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u>
20 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inter-trochanteric Fracture of Right Hip.</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>Fell at Home</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>11:20 p.m.</u> <u>Feb. 4 1966</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) (County) (State)
<u>Funkstown Wash Md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Edward W. Ditto III</u> | | 22. DATE SIGNED <u>3-25-66</u> | |
| EXAMINER'S NAME (Type) <u>Edward W. Ditto III, M.D.</u> | | Address (Street, city, town, or county) <u>Hag., Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>3/28/66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Hagerstown Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Wm. A. Hunt</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u> | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| <div style="display: flex; justify-content: space-between;"> <div> <p>1. PLACE OF DEATH
a. COUNTY <u>Washington</u></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Washington County Hospital</u></p> </div> <div> <p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u></p> <p>d. STREET ADDRESS
<u>916 Pennsylvania Ave.</u></p> </div> </div> | | | | | | | | | | | |
|--|---|---|---|---|---|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print)
<u>Abraham</u> <u>NNN</u> <u>Vergers</u> | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>18</u> Year <u>1966</u> | | | | | | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>November 5, 1904</u> | 9. AGE (In years last birthday)
<u>61</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Drill Press Operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Mack Truck Co.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Haarlem, Holland</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Abraham Vergers</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Anna Catharine Beksvort</u> | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>214-09-7501</u> | | 17. INFORMANT
<u>Mrs. Hazel Vergers</u> Address <u>Hagerstown, Md. 916 Pennsylvania Ave.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u>
DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u>
<u> </u> Years <u> </u> | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sev. years</u> 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>3/17/66</u> 19 <u> </u> , and that death occurred at <u>12:30 a.m.</u> on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Howard N. Weeks</u> | | 22b. DATE SIGNED
<u>3/18/66</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>Howard N. Weeks, M.D.</u> | | | | | | | |
| 22d. ADDRESS
<u>580 Northern Avenue Hagerstown, Maryland</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>3/20/66</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rest Haven Cemetery</u> | 23d. LOCATION (City, town or county) (State)
<u>Hagerstown Md.</u> | | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>Wm. C. Kent</u>
<u>Rest Haven Funeral Chapel</u> | | ADDRESS
<u>Hagerstown, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>MAR 22 1966</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | |

2. 2. 2.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|-------------------------|---|---|---|--|--------------------------------------|--|---|
| 04483 | | | | | 04479 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | |
| a. COUNTY | | Washington | | | a. STATE | | Maryland | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | Hagerstown Maryland | | | b. COUNTY | | Washington | | |
| c. LENGTH OF STAY IN 1b | | 40yrs | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | Hagerstown Maryland | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | d. STREET ADDRESS | | | | |
| Western Maryland State Hospital | | | | | 31 W. Bethel Street | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | 4. DATE OF DEATH | | | | |
| First Middle Last | | | | | Month Day Year | | | | |
| EDNA CAROLINA WILLIAMS | | | | | March 2 1966 | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| Female | | Negress | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11-28-98 | | 67 yrs. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | |
| Domestic | | | Own home | | Pittsburg, Pa. | | | USA. | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| Charles Myers | | | | | Nettie Brooks | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| no | | | | Mrs. Louise Stewart | | 337 N. Jonathan | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMATOSIS
154X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF Recto-Sigmoid
DUE TO (c) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Not known
9 mos. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-11-1965, to 3-2-1966, that (I) (we) last saw the deceased alive on 3-2-1966, and that death occurred at 4:45 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | |
| [Signature] | | | 3-2-66 | | H. R. TURRO RIEGO | | 1500 PENNA. AVE. Hagerstown, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) (State) | | | |
| Burial | | 3-5-1966 | | Rose Hill Cemetery | | Hagerstown Md. | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| John R. Watson of Hagerstown Md. | | | MAR 8 1966 | | Charles Judge | | | | |

MEDICAL CERTIFICATION

04170

01886

Harvey A. Harrison
4070
Harborview Hospital
1. 1st Street

100A
100B
100C

100D
100E
100F

100G
100H
100I

100J
100K
100L

100M
100N
100O

100P
100Q
100R

100S
100T
100U

100V
100W
100X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 Film G377 6/9/66 mh

CERTIFICATE OF DEATH

04484

04480

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> | | c. LENGTH OF STAY IN 1b
<u>4 Days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> 21-1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>WASHINGTON COUNTY HOSPITAL</u> | | | | d. STREET ADDRESS
<u>838 Rolling Road</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Walter First Middle Last</u>
<u>WILSON</u> EDGAR WILSON | | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>17</u> Year <u>1966</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Mar 10 1888</u> | |
| 9. AGE (In years last birthday)
<u>78</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Architect</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Mass Boston Suffolk Co</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>William Wilson</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Adeline Jamison</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>Yes W.W.# 1</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
Address
<u>Mrs Nina B. Wilson 838 Rolling Rd</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>Fibro sarcoma - abdomen</u>
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 mo.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 9</u> , 19 <u>65</u> , to <u>Mar. 17</u> , 19 <u>66</u> that (I) (<u>we</u>) last saw the deceased alive on <u>Mar 17</u> , 19 <u>66</u> , and that death occurred at <u>8:20</u> AM, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Charles A. Hoffman</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>3/15/66</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Lloyd A. Hoffman</u> | | | | 22d. ADDRESS
<u>214 N. Pot-st. Hagerstown, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>3/20/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rehobath Cemetery near Hancock Fulton</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Ba</u> | |
| 24. FUNERAL DIRECTOR
<u>Hagerstown</u>
<u>Andrew K. Coffman Funeral Home Inc</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 22 1966</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

01180

RECEIVED

01180

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04485

Item 2 Film G374 3/22/66 mh

CERTIFICATE OF DEATH

04481

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Washington
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY W. Va. Wash. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
rural Hagerstown | | c. LENGTH OF STAY IN 1b
10 months | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bartow 85-3 | | d. STREET ADDRESS
Bartow 85-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Avalon Manor | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ANNIE Middle C. Last WOLFE | | 4. DATE OF DEATH
Month March Day 10 Year 1966 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 8, 1879 |
| 9. AGE (In years last birthday)
86 yrs. | | 10. IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
housewife | |
| 11. BIRTHPLACE (County & State, or foreign country)
Randolph Co., W.Va. | | 12. CITIZEN OF WHAT COUNTRY?
W.Va. | |
| 13. FATHER'S NAME
Solomon Cunningham | | 14. MOTHER'S MAIDEN NAME
Hannah Lantz | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Glenn G. Wolfe, N.Y.C., N.Y. | | Address
N.Y.C., N.Y. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral thrombosis
DUE TO (c) Generalized Atherosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
10 days
6 hrs
10 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 1958 to 3/9 , 1966, that (I) (we) lost the deceased on 3/9 , 1966, and that death occurred at 4:50 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
D E Martin | | 22b. DATE SIGNED
3/11/66 | |
| 22c. PHYSICIAN'S NAME (Type)
Donald E Martin | | 22d. ADDRESS
418 N. POTOMAC ST Hagg, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
cremation | | 23b. DATE THEREOF
3-11-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | |
| 24. FUNERAL DIRECTOR
Scott F. Minnich & Son, Hagerstown, Md. | | 25a. REC'D BY REGISTRAR
Charles Judge | |

04482

04482

Washington

Postmaster

10 months

Postmaster

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

Admission

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|---------------------------------|---|---|--|------------------------------------|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b LIFE
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
d. STREET ADDRESS 1921 GAY ST.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First JETTA Middle LORRAINE Last WOLFINGER | | | 4. DATE OF DEATH
Month MARCH Day 31 Year 1966 | | | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10/18/1929 | | 9. AGE (in years last birthday) 36 yrs. IF UNDER 1 YEAR: Months 3 Days 19 IF UNDER 24 HRS. Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JACOB R. ADAMS | | | | | 14. MOTHER'S MAIDEN NAME ELEANORA MULLENIX | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | 16. SOCIAL SECURITY NO. 218-24-8831 | | 17. INFORMANT MR. DAVID A. WOLFINGER | | | Address HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intestinal obstruction
5705 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) abdominal adhesions
DUE TO (c) Peritonitis | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 wk
6 wk | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hodgkins Disease | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/4/64 , 19 64 , to 3/31/66 , 19 66 , that (I) (we) last saw the deceased alive on 3/31/66 , 19 66 , and that death occurred at 2:15 PM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Robert V. Campbell | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 4/1/66 | | |
| 22c. PHYSICIAN'S NAME (Type) Robert V. Campbell | | | | | 22d. ADDRESS Hagerstown Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 4/2/66 | | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | | | 23d. LOCATION (City, town or county) (State) HAGERSTOWN MD. | | |
| 24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md. | | | | | 25a. REC'D BY REGISTRAR APR 5 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

04105

MASSACHUSETTS

WINTERBURY

1901

20 12

RUBIN

WINTERBURY

MASSACHUSETTS

10/10/1901

WINTERBURY

04105

MASSACHUSETTS

WINTERBURY

MASSACHUSETTS

WINTERBURY

WINTERBURY

WINTERBURY

10

WINTERBURY

WINTERBURY

WINTERBURY

WINTERBURY

04105

WINTERBURY

04105

WINTERBURY

04105

WINTERBURY

04105

WINTERBURY

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04487

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04483

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
rural Hagerstown | | c. LENGTH OF STAY IN lb
15 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rd # 3 | | d. STREET ADDRESS
Rd # 3 | |
| 3. NAME OF DECEASED (Type or print)
First ARTHUR Middle EUGENE Last YUTZY | | 4. DATE OF DEATH
Month March Day 17 Year 19 66 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 11, 1913 |
| 9. AGE (In years last birthday) yrs.
52 | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Plant maint. Super. | | 10b. KIND OF BUSINESS OR INDUSTRY
penal institu. | |
| 11. BIRTHPLACE (State or foreign country)
Mt. Savage, Md. | | 12. CITIZEN OF WHAT COUNTRY?
Md. | |
| 13. FATHER'S NAME
William H. Yutzy | | 14. MOTHER'S MAIDEN NAME
Alice Hice | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
217-10-4394 | |
| 17. INFORMANT
Mrs. Elizabeth Yutzy Hag. | | Address
Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Thrombotic Occlusion, Left Coronary Artery
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis, Moderately Severe Several years
DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Dr. E. W. Ditto, Jr. | | 22. DATE SIGNED 3-18-66 | |
| EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) Hagerstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | 23b. DATE THEREOF
3/19/66 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Lawn Mem. Gard. | 23d. LOCATION (City or Town) (County) (State)
Hagerstown Md/ |
| 24. FUNERAL DIRECTOR
Minnich Funeral Home | | 25a. REC'D BY REGISTRAR
MAR 21 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000